The Mid Yorkshire Hospitals NHS Trust

Dewsbury and District Hospital

Quality Report

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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
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

- We found within the trust there had been improvements in some of the services and this had meant a positive change in the ratings from the previous CQC inspection notably within outpatients and diagnostic services. In some domains in key services we noted improvements from our previous inspection findings but other factors had impacted on the rating so the rating had stayed the same. However we found in medical care, end of life services and community inpatients they either hadn't improved or had deteriorated since our last inspection.
- The trust had responded to previous staffing concerns and was actively recruiting to fill posts. Staffing levels throughout the trust were planned and monitored. However there were areas where there were significant nurse staffing shortages and these were impacting on patient care and treatment particularly on the medical care wards, community inpatient services and in the specialist palliative care team. There was also shortage of medical staff within end of life services.
- We found that most areas we visited were clean however there were areas in accident and emergency departments at Pinderfields and Dewsbury District Hospital and in the mortuary at Dewsbury and District Hospital that were not clean and infection control procedures had not been followed.
- Patients nutritional and hydration needs were not always assessed using the Malnutrition Universal Screening Tool (MUST). At our inspections we found that not all fluid balance and nutrition charts were fully completed which meant staff could not always assess the hydration and nutritional status of patients and respond appropriately where patients needed additional support.
- The trust had consistently not achieved the national standard for percentage of patients discharged, admitted or transferred within four hours of arrival to A&E. Pinderfields had not met the 95% standard for the previous 12 months and Dewsbury District Hospital had not met the 95% target for the previous 6 months.
- There was a governance structure which informed the board of directors. This was developed and implemented in 2014.

Summary of findings

- The trust had a vision for the future called “meeting the challenge”. This was detailed in the trust’s five year strategic plan 2014/15- 2018/19. The trust had developed an overarching strategy called “striving for excellence” which was detailed in the five year strategy. Underpinning the strategy there w five breakthrough aims which had key metrics against them so the trust could measure their performance against these.

We saw areas of good practice including:

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

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

Importantly, the trust must:

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

Summary of findings

- The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users.
- The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.

In addition the trust should:

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- The trust should ensure staff are involved and informed of service changes and re-design.
- The trust should take actions to address the historical management–clinician divides that had not been resolved amongst certain surgical specialities.

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 	A number of infection prevention and control concerns were identified e.g. lack of placement of alcohol gel, lack of use of alcohol gel, maintenance of the environment, general cleanliness of the environment. High levels of dust were found in the resuscitation, paediatric areas and assurance of equipment cleanliness was not provided. Toys were found for children to play with that were dirty. Access to patient toilet facilities were poor with only one toilet provided for patients use. Mandatory training rates showed low levels of compliance for both medical and nursing staff. Nursing staffing levels in the department were not appropriate with six WTE qualified nurse vacancies. Concerns were raised about the flow and capacity in the department. The trust acknowledged that ensuring safe nurse to patient ratios on inpatient wards had impacted on the number of beds available and therefore impacted on the delivery of the four hour standard. However this was now affecting the emergency department in that patients were now spending longer in the department and exit block was occurring and overcrowding was noted within the emergency department. Staff we spoke to and data we reviewed highlighted the issues. Ambulance handover times were consistently double the England average and handovers were only taking place within the recommended window of 15 minutes from admission on 85% of occasions. Admission to assessment (triage) was not always carried out within 15 minutes. On reviewing the urgent care improvement programme, key actions and performance outcomes within the quarter were identified but these had been highlighted as red or amber indicating these actions had not been completed within the expected timescale. No robust clinical governance structure existed between the three emergency departments (ED); attendance at individual site governance meetings was poor. The risk register had no items specific to Dewsbury within it. The visibility of the senior management

Summary of findings

team on the Dewsbury site was poor with the head of clinical service only attending infrequently and the matron only attending once a month when the site matrons rota required.

Medical care

Requires improvement

We had concerns regarding the registered nurse staffing levels particularly on the wards. There were infection control issues identified which included equipment not being appropriately cleaned, staff not appropriately following infection control procedures and poor hand hygiene. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples on how they had learnt from incidents and how improvements were implemented.
Throughout our inspections we found patients were not always monitored or supported with their nutrition and hydration needs. We found assessments and records were not always fully completed. We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal.
Generally patients and relatives stated they had experienced very good care. Patients told us on the whole buzzers were answered quickly; we noted this whilst on the wards. However some patients told us they had not experienced good care whilst on the wards.
We found the number of medical outliers had reduced on surgical wards since our last inspection in July 2014. We found the service had specialist roles to support people's individual needs which included a learning disability nurse and link nurses for dementia. There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.
There was a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than one hospital site.

Summary of findings

Staff told us the matrons were visible and supportive they told us a matron was usually 'on site' at Dewsbury Monday to Friday. However some staff said they wouldn't know who the senior managers of the division were or trust board executives. Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Senior staff told us that each Friday they held a conference call to discuss risks across the division. Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.

Surgery **Requires improvement**

During this inspection we reviewed the progress made against the trust action plan and found that improvements had been made in certain areas however, there remained a number of areas which continued to require improvement; safe, effective, responsive and well-led. Caring was rated as good. Medical and nurse staffing levels remained a challenge; there were gaps in the medical rota which were predicted to rise and shortfalls in registered nurse time. Recruitment was ongoing however not all staff were yet in post. Staff received mandatory training but the number of staff that had completed mandatory training was below the hospital's expected levels.

There continued to be historical management-clinician divides that had not been resolved and tensions remained amongst certain surgical specialties leading to a lack of effective clinical engagement.

Mortality indicators were within expected ranges. Other indicators however, showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours and waiting times, such as the 18-week referral to treatment times and arrangements for the access and flow of patients on to the wards.

Summary of findings

Patient safety was monitored and incidents were investigated to assist learning and improve care. There were processes in place for infection prevention and control and the management of medicines. Improvements had been made to ensure all anaesthetic equipment in theatres was checked. There were some patient records which were not being consistently completed.
There were processes in place for staff to recognise and respond to changing risks for patients, including responding to warning signs of rapid deterioration of a patient's health

Critical care

Requires improvement

Overall we rated safety as requires improvement, the main concerns were regarding the staffing vacancies and skills mix resulting in the core standards for Intensive Care Units (ICU) not always being achievable. In addition, daily checks of emergency equipment were not always completed. Throughout critical care there was a lack of sufficient space for each bed area, subsequently meeting the Department of Health Guidance on the critical care environment was a challenge. We found the checks on resuscitation equipment on the High Dependency Unit (HDU) were completed with only two gaps in the records; however we saw on the ICU there were several gaps for the previous four months. The assurance that daily checks were being completed was not evident.

Maternity and gynaecology

Good

Overall at this inspection we rated the service as good. We found the checking of equipment in delivery suite was now taking place. The birth to midwife ratio had increased from 1:33 to 1:31 since our inspection in July 2014 and the specialist midwife roles for example the teenage pregnancy, and infant feeding midwives were not included in these figures. Positive feedback was received from women in relation to them receiving one to one care from a midwife during labour and records showed staff used a 'fresh eyes approach' (Fitzpatrick and Holt, 2008) when monitoring foetal wellbeing through the use of cardiotocography (CTG). The medical staff skill mix at the unit was in line with the England average, and the cover on the delivery suite was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance.

Summary of findings

Staff told us they were kept up to date with information about what was happening within the trust; senior managers were approachable and they knew who they were.

Services for children and young people

Good

At our inspection of the service in July 2014 we rated the safety domain as requires improvement. We had found that there was confusion over version control of risk registers. We also found shortages of nursing staff in all the areas we visited. We also found that the outpatient services for children at Pinderfields, Dewsbury and Pontefract hospitals, which were managed and run as one service did not provide enough flexibility to allow cover at all times. During our focused follow-up inspection in June 2015 we found that there was effective version control of the risk register. There were also improvements to the levels of nurse staffing in the outpatients department.

We found at the inspection in July 2014 that the hospital did not hold pre-assessment clinics, which meant consent was most commonly recorded on the morning of surgery. At this inspection we found that the trust was in the process of reviewing the provision of pre-assessment clinics and the process of consent. Parents we spoke with told us they were always asked for their consent prior to surgery, and a full explanation was given.

At the inspection in July 2014 we found that the service was not responsive to the needs of children and young people in that they did not have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes. At this inspection we found that although the service had appointed a consultant, one of whose roles was to lead on transition services, that significant changes had not been made since the previous inspection.

End of life care

Requires improvement

We found that end of life care services at Dewsbury hospital were inadequate for safety. Effectiveness, responsiveness and being well led all required improvement.

End of life care was provided across the hospital and supported by a specialist palliative care team. The team were focused on providing a high quality service for patients and their families; however shortages of staff and a lack of strategic vision were

impacting on the service they could deliver. We found both medical and nurse staffing within the specialist palliative care team to be of concern for the size of the service they were responsible for based on the number of referrals and information from the team indicating some patients were discharged before being seen. The team received 351 referrals from April 2014 to March 2015, an average of 29 per month. We found senior leaders did not have full awareness or understanding of the challenges of the service, they told us the team was adequately staffed.

There were poor infection control practices in the mortuary and inappropriate methods of transporting deceased infants from the wards to the mortuary. We found the corridors outside the viewing room and mortuary was not suitable for bereaved families to walk through.

We were not assured that the procedure for documenting involvement of patients and relatives with do not attempt cardiopulmonary resuscitation (DNACPR) decisions was in line with the mental capacity act or accordance with best practice, nor that trust policy was being followed.

The process for rapid discharge of patients at the end of life was protracted and lengthy. Not all areas had been trained to use or were using the end of life care plan.

We saw evidence of good multidisciplinary working between different disciplines. Bereavement staff and the chaplaincy service supported patients and families and were responsive to their needs. End of life care on the wards was provided in a compassionate and dignified way.

Outpatients and diagnostic imaging

Good

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

diagnostic imaging equipment and staff working practices were safe and well managed. New equipment had now been purchased for pathology and would be in the trust from July 2015. There were planned dates for going implementation on 5 November 2015 for biochemistry and January 2016 for haematology.

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

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

Management teams had a vision for the future of the departments and were aware of the risks and

challenges they faced. There were monthly governance meetings where trends from incidents and risks within the division were discussed. Staff reported they now had a secure management structure and staff were positive about the changes the management team had brought to the service. Staff throughout the service told us they felt the culture within the organisation had changed.

Dewsbury and District Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Dewsbury and District Hospital

Dewsbury and District Hospital is part of the The Mid-Yorkshire NHS Trust. It is situated in the Dewsbury area and serves a population of approximately 185,000 people in the local North Kirklees area. The trust employs around 6,772 members of staff including 740 medical & dental staff.

The hospital provided a full range of hospital services, including an emergency department, general medicine, including elderly care, general surgery and maternity care. The hospital had approximately 358 beds.

The health of people in Kirklees is varied compared with the England average. Deprivation is higher than average and about 18.6% (15,900) children live in poverty. Life expectancy for both men and women is lower than the England average. The population had a similar age group breakdown to the England average. In the Kirklees area there was 20.8% BAME residents which was a higher proportion than the England average of 14.6%.

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

Our inspection team

Our inspection team was led by:

Chair: Dr Bill Cunliffe

Head of Delivery: Adam Brown, Care Quality Commission

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

Detailed findings

How we carried out this inspection

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

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

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

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

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

Facts and data about Dewsbury and District Hospital

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

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

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

On the DDH site they have approximately 83,129 admissions per year which equates to approximately 250-300, patients a day 7557 patients per month July 2014 to May 2015. Paediatric admissions for the year had increased with attendances of 21,736 in January 2013-14 and 23,999 in Jan 2014-15.

Of the total number of patients attending 14,848 patients (15%) of these resulted in admission to hospital which was lower than the England average of 21.9%. The emergency department was open 24 hours a day, seven days a week. A new GP service has been commissioned and is operating 5pm till 9pm from the department attendance figures were not available.

The department has a reception, 'majors', 'minors' and paediatric dedicated areas. Patients with a minor injury or illness are treated in the minors' area. Those patients with a more serious injury or illness are treated in the majors' area. There are designated nurses and doctors allocated to each area. The paediatric area is staffed by a designated doctor and 2 registered children's nurses between 9am and 9.30pm with 1 dedicated registered nurse overnight (not a registered children's nurse).

In the adult emergency department (ED) there are two assessment cubicles and 14 trolley cubicles. The trolley cubicles were divided into two bays with six and eight beds respectively. The resuscitation area was able to care for four patients; this included one resuscitation trolley area that was equipped for the care of children. Mobile X-ray facilities were available for acutely ill patients or if stable patients went to the main radiology department. The children's area could care for three patients on trolleys and two sitting in cubicles. There was a dedicated waiting area for children which had toys. Paediatric admissions were accepted 24 hours a day.

During inspection we spoke to 8 patients and 20 members of staff including nurses, support staff, doctors and ambulance staff. We reviewed 11 sets of records.

Staff had recently introduced co-ordinator handover forms to handover issues that had happened during the shift. These were in the early stages of use, however staff told us about the benefits of improved communication.

Urgent and emergency services

Summary of findings

There were concerns over sharing of lessons learned from incidents, root cause analysis and serious incidents throughout all the three Emergency Departments (ED).

A number of infection prevention and control concerns were identified e.g. lack of placement of alcohol gel, lack of use of alcohol gel, maintenance of the environment, general cleanliness of the environment high levels of dust were found in the resuscitation, paediatric areas and assurance of equipment cleanliness was not provided. Toys were found for children to play with that were dirty. Access to patient toilet facilities were poor with only one toilet provided for patients use.

Mandatory training rates showed low levels of compliance for both medical and nursing staff. Receptionist cover had been intermittent in the previous months due to ED receptionist sickness rates throughout the trust. Nursing staffing levels in the department were not appropriate with six WTE qualified nurse vacancies.

Concerns were raised about the flow and capacity in the department. The trust acknowledged that ensuring safe nurse to patient ratios on inpatient wards had impacted on the number of beds available and therefore impacted on the delivery of the four hour standard. This meant within the emergency department patients were now spending longer in the department and exit block and overcrowding was occurring within the ED. During the inspection the department was quiet so we did not witness this, however staff we spoke to and data we reviewed highlighted the issues. The trust acknowledged that ensuring safe nurse to patient ratios does impact on the number of beds available and therefore impacts on the 4 hour standard.

Ambulance handover times are consistently double the England average and handovers were only taking place within the recommended window of 15 minutes from admission on 85% of occasions. Admission to assessment (triage) was not always carried out within 15 minutes.

During the inspection it became clear that staff working within the department did not understand the 2017 vision for the three EDs. On reviewing the urgent care improvement programme, key actions and performance outcomes within the quarter were identified but these had been highlighted as red or amber indicating these actions had not been completed within the expected timescale. No robust clinical governance structure existed between the three ED; attendance at individual site governance meetings was poor. The risk register had no items specific to Dewsbury within it. The visibility of the senior management team on the Dewsbury site was poor with the head of clinical service HoC only attending infrequently and the Matron only attending once a month when the site Matrons rota required.

The department used National Institute of Clinical Excellence (NICE) and CEM based guidelines. A positive relationship was noted between multi-disciplinary team and the ED. A staff spoke highly of their colleagues and visibility of the ED senior management team was good on the Pinderfields site. The department had good level of participation in audits of the College of Emergency Medicine (CEM) Standards.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

There were concerns over trust wide and departmental learning and sharing of lessons learned from incidents. Incidents were shared internally in the hospital; however sharing did not occur between departments on each site. Medical and nursing staff were not aware of their actual top three incidents from incident reporting, learning from serious incidents and the root cause of the incident was not fully disseminated. Staff reported incidents of patients deteriorating due to the high number of patients in the department.

Mandatory training rates for medical staff and nursing staff were poor with low levels of compliance. Receptionist cover in the main department had been intermittent in the previous months due to ED receptionist sickness rates.

There were a number of infection prevention and control issues identified such high levels of environmental dust in the resuscitation department and in the paediatric ED. Some alcohol gels were found to be empty and gel was not always available at the point of use. Toys were found to be unclean, the toy policy was not approved and was out of date.

The environment and equipment was observed and was found to be unclean, and not well maintained. Equipment was stored inappropriately.

Staffing levels were of a significant concern as six whole time equivalent (WTE) vacancies were noted, established staffing levels were rarely met. There were risks to patients in the department when extra capacity areas were opened.

Triage of patients was not always carried out according to national standards and patients were not always assessed within the 15 minutes for booking.

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

Personal protective equipment were available and bare below elbows policies were maintained. Infection prevention control (IPC) audits were undertaken and had mixed results. Good levels of pressure ulcer reporting were found.

The emergency department used a centralised computer records system. Patients' records were completed. A designated consultant lead for major incidents was identified.

Incidents

- Dewsbury ED reported 165 incidents (rated as harm which was moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between Feb 2015 to May 2015.
- None of the incidents were graded as severe, 7 were graded as moderate harm, 51 low and 108 as no harm/ near miss.
- All incidents within the ED were reported through a centralised reporting system. There was a total of 166, however one was a duplicate so 165 incidents had been recorded on the system since February 2015. Senior nursing and medical staff reviewed the incidents, reported and analysed the data to identify any trends.
- Staff we spoke to were aware of their roles in relation to incidents and there need to report, provide evidence, take action, triage or investigate as required. All incidents were reviewed by the matron and then disseminated to the area lead for ED.
- Learning from incidents was shared internally in the sisters meetings, a communications book, and email system. However no formal mechanism existed to disseminate lessons learned throughout the three ED's. Staff spoke to us about the communication book used to handover key messages to all staff, and the agreement by medical staff to read the book at least once a week. Medical staff spoke to us about how they cascade lessons learnt from incident to junior medical staff, and the processes involved if a medical trainee was involved in incidents. Trainee staff spoke to us about how they recorded incidents their personal portfolios.
- The trust made incident data available, we reviewed incident data: a total of 165 incidents had been recorded on the system since February 2015. We identified that the top three incidents were pressure ulcers 100/165, staffing incidents 8/165 and possible delay or failure to monitor 7/16. Nursing staff we spoke

to were not all aware of the top three incidents within the ED, some staff told us they were pressure area care, staffing levels and blood labelling incidents. Others said they were falls and IPC. Medical staff spoke about one of the top incidents being community acquired pressure ulcers. Staff, who didn't attend the governance meetings, spoke to us about the top three incidents as being drug errors, verbal abuse and needle stick injuries.

- Staff spoke to us about some specific lessons learnt from incidents arising from patients loosing property and a change of practice that has now occurred as a result of the incidents.
- Senior nursing staff have an update of incidents via the leads meetings and they are shared on the nursing dashboard and these are reviewed at the lead nurse's one to one meetings with the matrons.
- The trust was signed up to the NHS England "Sign up to safety campaign" a national initiative to make the NHS the safest system in the world, the senior medical and nursing team did not make reference to this campaign when incidents were discussed.
- Serious Incidents (SI's) are incidents that require further investigation and reporting. Ten serious incidents had been reported on the STEIS (strategic executive information system) within the three EDs at the trust. We requested serious incident reports and no reports were supplied from Dewsbury. One SI was recorded on the Pinderfields site about elevated cardiac blood levels and a failure to review in a timely fashion in September 2014, on reviewing the root cause analysis report recommendations had been put in place including a memo to all long-term junior doctors, however on reviewing incident data for Dewsbury a similar issue had arisen on the Dewsbury site in May 2015.
- Root cause analysis investigations were undertaken in the ED, staff told us the process for dissemination post review was a memorandum, email dissemination and documentation in the communications book. We reviewed one report from Dewsbury and when we questioned the staff regarding the incident staff were able recognise the incident and describe some of the recommendations from the incident.
- Never events are serious incidents, wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level. No never events had been recorded.
- The department did not hold specific mortality and morbidity meetings however there was evidence this was discussed as part of the governance meetings.
- On reviewing incidents from Feb 2015, two incidents had been recorded where handover of the patients had not been received adequately from the ED to the receiving ward. Another incident was logged were communication regarding a patients discharge had not been received at the community care facilities leading to community visits not being re-started on patient discharge. A root cause analysis investigation showed failure in communication to the ambulance staff on transfer and staff on the surgical assessment unit. One of the recommendations from this incident was the written document for handover transfer and also staff to be taught the importance of verbal handover, however this practice is not embedded as two further incidents occurred in the following few months.
- A safety brief handover had recently been developed which contained information regarding staffing, movement of staff, sickness, numbers of agency staff and numbers of patients in the department including the acuity and dependency of patients. This has been developed to aid handover by providing a seamless transition between co-ordinators when the department is busy.

Duty of Candour

- Staff spoke to us about their knowledge of duty of candour and being able to tell patients if an incident or mistake had occurred and about the need to be open and honest. They spoke about offering patients face to face meetings to discuss incidents.
- Staff were aware of the need to record this discussion and space was available on the reporting system for this recording.
- As part of the serious incident reports duty of candour was commented on and we were able to see that discussion had taken place with the family.

Safety Thermometer

- In the reporting period July 2014 to Dec 2014 overall in the three EDs, 20 harms had been reported under the safety thermometer reporting system. 4 pressure ulcers were recorded in Oct/Nov 2014, none recorded in the

previous 9 months. 12 falls were recorded these peaked in February 2014 and reduced towards the end of the reporting period. 4 catheter related urinary tract infections were recorded.

Cleanliness, infection control and hygiene

- One of the must do's in the CQC 2014 report was to ensure that all equipment in the accident and emergency department is appropriately cleaned, labelled and stored in the correct environment. "I am clean" assurance stickers were in use during the inspection, however their use was not consistent and equipment was found in inappropriate conditions. In an internal infection prevention and control IPC audit report in December 2014 patient equipment cleanliness scored 100%. In April 2015 a specific action plan for IPC was reviewed and equipment was found to be not labelled and some equipment was found damaged and dirty. Further internal inspections had taken place and some improvement had been noted, with the last of these checks taking place in June 2014.
- We observed that staff complied with the trusts policies for wearing the correct personnel protective equipment such as gloves and aprons. Stocks of personal protective equipment were readily available.
- We observed that five alcohol gel dispensers were checked throughout the department and three weren't working we highlighted this directly with staff. We also noted alcohol gel was not available on the trolleys. Sinks for hand hygiene were limited around the department. No hand hygiene basins were present in the curtained cubicles in the children's ED; alcohol gel was also not present in every area. We did witness medical staff attending to patients without carrying out hand decontamination.
- Only one hand hygiene sink was available in the resuscitation area, a decontamination sink was available in the middle of the resuscitation area.
- Adherence to the "bare below elbows" policy was good with all staff observed as being "bare below elbows".
- There had been no cases of MRSA or Clostridium difficile acquisition within the ED noted in the previous year.
- Staff talked to us about a recent admission of patient with an unusual infection and how they had been nursed in isolation pre transfer in the decontamination cubicle at the end of the department.
- We observed domestic cleaning schedules being available the ED and staff told us that domestic staffing is fully covered with staff present morning, afternoon and extra funding had recently been identified to provide extra domestic cover overnight.
- Staff told us that recently the trolleys and floors had all been deep cleaned.
- The NHS carries out audits against set standards to monitor the level of cleanliness, the national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes April 2007. At the previous internal audit in June the department scored 98.25%. Emergency department are routinely classified as very high risk departments (98% compliance) when we asked the domestic team for clarity around the audit classification, they were not able to provide this. The standard of cleanliness we saw during the inspection did not indicate compliance with the standard.
- During the inspection two patients complained to the inspection team that the main toilet in the department was dirty, we inspected the toilet and found it to be dirty and stained, the soap dispenser also wasn't working. We highlighted this to a member of staff and when we inspected later it was found to be clean and the soap dispenser was working.
- The resuscitation area during the first visit was found to have debris on the floor and during the second visit it was found to be very dusty and visible dirt was present behind every piece of equipment on the floor, high dusting was also poor in cubicle 1, we highlighted this directly with staff.
- The children's ED was inspected and found to be extremely dusty with balls of fluff coming off equipment and behind trolleys. This was witnessed by department staff and highlighted directly to the domestic supervisor who attended the department.
- There were a lot of toys present in the children's ED waiting area and when checked many of these toys were found to be unclean. Dust and debris was found underneath and within the toy boxes. Wooden toys were present with damaged laminate making toys difficult to clean. Toys were seen that had small grooves and channels that are difficult to clean.
- On checking the trust guideline for the management and maintenance and safety of play equipment if was found to be a document that had been through approval and trust sign off.

- The floor in the children's ED waiting area looked dirty and debris was found, old stickers were stuck to the floor. The walls in the children's ED cubicles were dirty with staining and marking present.
- Due to the cleanliness within the department we asked for the domestic supervisors to attend the department, which they did and we reported the concerns directly to them during the inspection.
- The department had a full range of equipment, cleaning assurance labels were used on some equipment, however it was not observed to be used routinely as we observed one commode labelled and one commode was not.
- A syringe driver was found in the resuscitation area which was labelled as clean 3 weeks prior to the inspection.
- We observed mattress inversion taking place, tipping the trolley mattress on its side was used on site to indicate cleaning had taken place, this was seen on the second visit to the ED. Staff we questioned told us that following discharge of a patient it was normal to clean the trolleys and place the mattress on its side with a cleaning label attached for assurance of cleanliness, however during the first inspection visit to Dewsbury no mattresses were seen to be stored on the trolley in an inverted way. Despite this procedure taking place we found trolleys with balls of fluff on the underneath of the trolley.
- During our inspection the cleaning trolley was left unattended for 10 minutes in the waiting area which had cleaning products located on it**.**

Environment and equipment

- The department was made up of a three bedded resuscitation department for adults and one bay for paediatric admissions. 14 trolley cubicles were available for minor and major patients. Two cubicles were used for rapid assessment of patients and allowed patients to be assessed lying on trolleys.
- The resuscitation room had recently been decluttered, however was still very cluttered with equipment being stored on windowsills, laminate on shelving units was damaged.
- No room was available that was dedicated to treating patients with mental health needs.
- The minor injury area shares the department with the GP walk in centre in a morning and then minor injuries move into the fracture clinic area in the afternoon. Staff spoke to us about them using the fracture clinic area as a nurse practitioner area only on an afternoon, and the pressures this placed on the ED department in the morning.
- The relative's room was very dated and lacked basic facilities such as a kettle for relatives to make drinks.
- In the main ED department access is only available to one toilet for patients. Other toilets were available in the waiting areas.
- The paediatric emergency department was very small for the amount of attendances, due to the number of attendances staff reported that they sometimes have to flex the department into the minor injury cubicles. This is achieved through opening the locked door from the minors department into the paediatric area, once open this leaves paediatric patients in an unlocked department and presents safeguarding issues.
- During the inspection we spent time in the children's ED waiting area and 18 people were currently waiting this included two pushchairs. During the time we were in the waiting area 3 more people arrived and there were no seats. 3 more people then arrived in the waiting area, two adults and a child. The child became very scared and ran out into the department due to overcrowding.
- The paediatric emergency department has three open curtained cubicles and two cubicles with a door. It was decorated in bright and colourful child friendly designs on the walls; however some of these designs were not laminated and were difficult to clean. It was well equipped with children's toys and play facilities.
- A small waiting area is present in the children's ED which leads directly into a toilet area with baby changing facilities. The toilet area was damaged with laminate lifting and peeling on the pipework. The back of the toilet area was damaged and brown stains were present on the sink.
- The paediatric resuscitation trolley was labelled as being checked but was extremely dusty. Two pieces of equipment were found in the trolley, one was out of date and one had been open and placed in a different plastic sealed bag than original manufacture so no assurance over cleanliness or dates were present. These were reported directly to the nurse in charge of the children's ED and replacements arranged.
- Not enough fixed storage was present in the children's ED and linen was stored on a trolley covered with a material covering on the corridor.

- The overall department was very cramped and had a lack of storage. Ebola preparedness equipment was stored in the corridor covered with a sheet to prevent dust; however this was found to be dusty in internal IPC audits in the previous months. Staff were aware of a business case that was in development for environmental upgrade, we were told that a £1.3 million business plan was to be taken to the trust board in the following week for discussion, with plans to start and finish the project in 2016.
- Overall the environment was found to be poor with damaged wood and laminate being present, floors were found to be damaged and tape was applied to a corridor floor leading into a team area. Having tape on floors makes it very difficult to clean.
- Staff we spoke to were aware of the constraints in the department and spoke about plans that get discussed for expansion; however they are unaware of any dates for commencement of any work.
- Staff reported that if the department is run as per design they had enough equipment, however due to the recent flow issues they did not have access within the department to enough patient trolleys, so they requested extra that were supplied from the day theatre units.

Medicines

- There were processes in place for ensuring medications were kept securely. Medication fridges were found to be locked when we randomly checked them. Fridge temperatures were manually recorded and were within expected limits.
- All medicines cupboards were found to be locked and drugs were stored in order and date.
- Controlled drugs were stored according to legal requirements. Controlled drug books were checked are completed with signatures and dates.
- Allergies were recorded on patient record cards and within the IT patient administration system.
- Patient Group Directives (PGDs) are written instructions which allow non-prescribing healthcare workers to supply and administer specific medications to patients who meet set criteria. The use of PGDs is underpinned by legislation (Human Medicines Regulation 2012, the Misuse of Drugs Act 1971 and the Misuse of Drugs regulations 2001). We reviewed PGDs within the department and found them all appropriate for drugs used within ED and we observed them to be fully signed individual by staff.
- Staff reported to us that medication competencies were assessed and were currently being updated.

Records

- The emergency department used an electronic patient record system widely used within the NHS. Nursing and medical documentation in the ED was stored electronically.
- All staff were provided with access to the system and provided with training on how to use the system. Locum staff also had access.
- Staff talked to us about information held on the system and staff could also scan further information into the system such as observation sheets.
- We reviewed 11 sets of patient records who attended the department during the inspection. We found the documentation to be concise and it was completed in a timely manner.
- Paper records were found to be handled and stored securely. The trust provided information governance training compliance data for ED which showed compliance at 95% for nursing staff and 67% for medical staff.

Safeguarding

- The department had systems in place to safeguard vulnerable adults. Nursing and medical staff we spoke to were able to explain to us about safeguarding procedures for both adults and children and were aware of their responsibilities and appropriate safeguarding pathways to use to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.
- Safeguarding training was incorporated into the induction process for junior medical staff; the trust provided safeguarding compliance data for ED which showed compliance at 100% for safeguarding level 2 and 3 training.
- Staff were able to discuss issues around sexual exploitation and female genital mutilation. These issues were contained within the level 3 safeguarding programme. A symbol was present on the computer system which highlighted children at risk.

- Staff were aware of whom the key individuals were to report safeguarding concerns for maternity, children's and adults patients.

Mandatory training

- One of the must do's in the CQC 2014 report was to ensure that all staff attend and complete mandatory training and role specific training particularly for safeguarding and resuscitation. Information about levels of compliance with statutory and mandatory training was supplied to us by the trust pre-inspection: compliance for medical staff averaged 87%; and nursing staff 80.5%. Resuscitation training compliance data supplied by the trust was low with 76% nursing staff and 50% medical staff completing training. Senior staff were aware of their training compliance rates and their need to ensure compliance. Staff talked to us about the current staffing levels hampering compliance with mandatory training.
- Statutory and mandatory training was delivered by a mixture of face to face and e-learning training sessions. Staff we spoke to told us about new e-learning training programmes they accessed, they highlighted difficulties they had accessing the system at work as the programmes freeze and crash. Remote access at home to complete their e-learning has been arranged.
- Medical staff new into the ED spoke to us about attending a 3 day induction programme containing the training required for mandatory training.

Assessing and responding to patient risk

- Patients arriving by ambulances were brought in through a dedicated entrance and were initially assessed by a nurse who carried out initial assessments. Staff told us they used national Early Warning Scores (EWS) to assess adults.
- Children arriving by ambulance were transferred into the paediatric area or the paediatric resuscitation area. Paediatric early warning scores were used to assess children.
- Patients arriving on foot initially check in, at a small reception area. We observed that this area gets very crowded and is difficult to maintain patient confidentiality. This area is the main route in and out of the department so it gets very congested.
- There was a patient's book in at reception for both ED and the GP walk in centre, the waiting area was shared.
- Patients are allocated to be seen by the nurse practitioner using set criteria on the computer this shows on the computer system as a blue chair.
- A minor injuries route also exists with patients waiting in the main waiting area and then being called by a nurse practitioner for see and treat treatments.
- Paediatric patients are called to wait in the paediatric waiting are by the nursing team and the adult patients wait to be seen by the triage nurses.
- ED patients are called by the triage nurse. We observed nurse triage whilst we were in the department. Triage was staffed by senior nurses whilst we were in the department, staff told us triage is provided by senior staff in the morning and staff nurses in the afternoon or evening, staff are declared competent before providing triage alone.
- Waiting times for triage during our inspection were within the recognised timescales of 15 minutes from attendance. However on examining dates in the previous two months we noticed that on some occasions patients were waiting for assessment longer than the timescale with patients waiting between 18 and 50 minutes.
- A two bedded initial assessment area is available where patients admitted directly on foot to ED or via ambulance are assessed prior to attending the minor's stream or the majors stream.
- The department is not listed as a major trauma centre, however they did receive ambulance patients and trauma patients on foot
- The ED co-coordinator completes a breach report at the handover of each shift, 4 breaches happened on the day we visited ranging from 4 hours 58 minutes to 7 hours 42 minutes. Reasons for the breaches were recorded as one waiting for patient transport, one waiting for diagnosis and two clinical breaches. Staff talked to us about two breaches recently where patients had been in the department 18 hours and 14 hours however these were not classed as over 12 hour breaches as the decision to admit them was not made until part way through of their stay in ED.
- Staff told us they used early warning scores (EWS) and nursing staff used this to escalate patients to medical staff for review. Staff were aware of the need to refer patients with an EWS over 6 to the outreach team.
- Staff showed us the resuscitation charts used that had been designed by a nurse, to document all changes to care given escalation plans were clear if there were a

high number of patients. We reviewed the standard operating procedure for managing emergency demand. It is clear from the actions contained within the communications book and the site co-ordinators meeting documentation that staff understand this policy and the escalation routes.

- During inspection, in the resuscitation area, we heard loud shouting behind the curtained area. A male patient was being treated in here; the patient was very distressed, confused and agitated. The patient was being physically aggressive towards staff, staff remained very clam trying to talk to the patient and reassure him, security was called and two security guards attended quickly, these were backed up by two porters offering help. A doctor wanted to cannulate the patient, however this was difficult and a conversation was witnessed between staff obtaining consent from all if restraint was required to place the cannula, it was decided that this was in the patient's best interests. The inspection team witnessed restraint being used to insert cannula and sedation to allow radiological scanning to take place. We requested review of the restraint policy used in the ED and found actions taken to be appropriate as they were reasonably anticipated, agreement was reached and support had been requested.

Nursing staffing

- One of the must do's from the CQC 2014 reports was to ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner. Staffing in the Dewsbury ED was observed to be poor at the time of the inspection with 6.7 WTE vacancies. We noted 9 incident forms completed at Dewsbury throughout the previous five months were inappropriate staffing levels were noted; on reviewing the communications book for May 2015 we noted that staffing levels had been escalated 20 times in the month to the site managers.
- No best practice tool for nurse staffing was currently available for EDs. The trust had recently undertaken a staffing establishment exercise in relation to staffing ED, as the trust Director of Nursing had been a member on the NICE national working group establishing the staffing ratios for ED's. The trust had scoped staffing requirements at Dewsbury in line with one nurse to four patients, and one to one or two to one for patients in resuscitation areas as described in the draft NICE safer staffing in ED guidelines. However at the point of inspection this document had not been published, so the staffing establishments had not been implemented.
- Current established staffing levels are agreed as 11 nursing staff to be on duty in the morning (8 qualified (6 main department) and 2 paediatric nurses and 3 HCA), 12 nursing staff for the pm shift (9 qualified (7 main department) and 2 paediatric nurses till 9.30pm and 3 HCA) and 8 nursing staff for the night shift (7 qualified and 1 HCA).
- Staff told us that they felt staffing levels were not adequate, due to the increased acuity of patients and increased lengths of time spent in departments. Staff also spoke to us about only one member of staff being left alone in the resuscitation department, and staff being "scared for their registration"
- When we compared the staffing levels to attendances it is noted that although attendance of patients at Dewsbury and Pinderfields were similar, established staffing rates were lower on the Dewsbury site.
- Band 5 staff had rotational posts between Dewsbury and Pinderfields site. In the urgent care improvement programme this is noted to be extending to other grades of staff. The rotation was developed to increase and maintain nursing staff core skills, but also to help with recruitment. Currently Dewsbury was able to recruit to the vacant posts, however they were getting only a small number of applicants and when they offered the position; some staff were giving back word and not accepting the position. It was hoped that by offering rotation this may improve recruitment.
- Recently the trust has commenced agency bookings through a different agency and staff said this has increased the competency of staff as they are often staff who work in Mid Yorkshire trust, or work in another ED department often at a senior level.
- The use of overtime has been recently agreed in the weeks leading up to inspection. Medical staff expressed to us concern over the skill mix of nursing staff as many staff are newly qualified and are learning the skills required to be an ED nurse.
- On the day of inspection the department was fully staffed with 6 qualified nurses and 3 healthcare assistants (HCA) and 2 paediatric nurses, one agency nurse was included in the numbers on duty. Seven nurses were planned on the late shift with three HCA and four qualified and one HCA on the nightshift.

- Sickness rates for nursing staff were 5.14% (April) higher than the England average of 4.81% (July to September 2014). It had been as high as 6.96% in previous 6 month period. On the day of inspection two members of staff were on long-term sick leave and one was on maternity leave.
- On inspecting six previous days rota we found five out of six days that nursing staffing levels were below the planned established amount, and on one occasion staffing levels were down by two qualified nurses and two HCA on a morning shift. We also observed that even though ED staffing levels were low at this time the ED had been requested to transfer the only HCA to go and work on the wards within the hospital. We saw that on this occasion as the department was busy and staffing was already short, the co-ordinator refused. We saw evidence of a day in the months prior to inspection when staffing levels were low with one qualified nurse below establishment and the department was at level REAP 5 alert. At 12 midday, 50 patients were in the department, eight patients were awaiting beds and 13 patients waiting in majors.
- On another occasion we saw evidence where staffing numbers were lower than establishment: two qualified and one HCA short; staff identified this issue to management, however management were unable to identify any help from the wards.
- Nursing staff shifts are staggered throughout the day to ensure that there are sufficient numbers at the times of peak demand. Handover are arranged formally twice a day, and informal handovers are held when required.
- We reviewed information supplied by the trust that gave details of the number of diverts. There was 19 internal diverts (between the 3 sites) mixed between GP and blue light ambulance diverts had occurred in the three months period April 2014 to June 2104, with most of these (17 out of 19) being diverts into Dewsbury. We noticed on two occasions, staff were raising concerns over the placing of diverts to Dewsbury due to staffing concerns on the Dewsbury site.
- Staff were aware of their usage of agency staff and they told us that recently agency staffing has improved as a different agency is being used; staff used by this agency were ED nurses from the Yorkshire region. A checklist had been developed to assist agency nurses if it is the first time they have worked in the ED. Within the internal communications book on three occasions, within the previous two months agency staff have not arrived for a shift, leaving the department short staffed. On one occasion it is reported that the department was staffed by "mainly agency staff" however an internal divert was in place to Dewsbury.
- Receptionist staff spoke to us about shortages with receptionists across all sites and that leaving receptions short staffed, this often leaves the ambulance receptionist unable to be located on the reception desk in the main department. Ambulance staff told us that this increases the time of their handover as they have to wait to book the patient in. Sickness rates for receptionist staff throughout the trust was 2.27% (March) lower than the England average for administration and estates staff (3.50% July to September 2015). Sickness within the administrative group had been as high as 15.81% in the previous 6 months, higher than England average.

Medical staffing

- There were a dedicated team of seven consultants employed to support the ED department at Dewsbury. 5 were substantive posts and there were 2 vacancies that were covered by long-term locum contracts. The consultant team described themselves as a close group of colleagues. Consultants contracts are permanently based at DDH, however new consultants have a trust contract enabling them to work on any site. Occasionally when a divert is in place the diverting hospital can send a member of medical staff with a patient.
- Registrars rotate round the different ED's in the trust. Junior doctors stay just on the Dewsbury site for their ED rotation. They work on a 10 place rota funded by the Deanery.
- Consultant cover was available 24 hours a day seven days a week. Consultants were available on site Monday to Friday 9am until 9pm and 9am till 5pm Saturday and Sunday and on call cover during the night. One consultant had a specific lead for paediatric medicine.
- Sickness rates for medical staff 2.71% (April) previous 6.91% in previous four months higher than the England average for medical staff of 1.12%. Staff talked to us about one of their worries being medical staff becoming unwell and being unable to work. On reviewing the communications book two occasions were noted were medical staffing was low because of staff sickness.
- Medical staff spoke to us about the changes in the department about patients increased acuity and the

time spent in the department they felt that established staffing levels were no longer correct. When we compared the staffing levels to attendances it is noted that at Dewsbury they had two consultants on duty daily with 250-300 attendances per day, on the Pinderfields site staffing was set at three consultants per day for 250-300 attendances.

- Permanent medical staff were aware of the amount of locum medical staff they use within the department, they told us they try where possible to maintain a core group of locums used. They also spoke to us and are aware of the need for induction in the department so they are currently working together on a concise induction pack for locum staff, however in the governance minutes it is noted that this has been on the agenda for six months with no apparent action. Staff also told us about the varying quality of locum medical staff, they were very clear on the routes to escalate any competency concerns.
- Senior medical staff spoke to us about being overworked, however being able to manage. Junior medical staff spoke to us about good support networks and working relationships with senior colleagues, they felt able to go to seniors for advice, support and guidance.
- Staff told us about a very good working relationship between the medical and surgical team.
- Despite the national recognised scheme "hello my name is" being adopted by the trust we heard two members of medical staff attended to patients in the ED without introducing themselves, we highlighted this to the nurse in charge.
- During the inspection a patient reported to us medical staff had not treated them respectfully, and they felt had not ensured confidentiality by asking medical questions in front of others. We reported this issue to the nurse in charge of the department. We also became aware of complaints about the attitude of a member of medical staff. Handovers are arranged formally twice a day, and informal handovers are held when required.

Major incident awareness and training

- There was a designated major incident store within the department. The department was equipped with a decontamination room; this room had also recently been redesigned to allow direct access from outdoors. A designated lead consultant covered all three EDs.
- A major incident policy was in place, this was reviewed and found to be detailed and in date, last reviewed in May 2015. A lead for major incidents in ED is identified and on the Pinderfields site two nurses were identified as responsible for checking the major incident equipment. On the Dewsbury site it was unclear whose role this was.
- Staff we spoke to had a clear understanding of their roles and responsibilities with regards to major incidents. Although staff told us that an exercise had not been rehearsed for some years, the trust confirmed that there was a full live exercise in 2013 and a table top one in 2014. Staff did tell us about incident training in preparedness for infectious disease patients and about a screening tool used for suspected infectious disease patients asking about travel, exposure and symptoms.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Patient fractured neck of femur (NOF) outcomes highlighted poor compliance to the standard overall in the trust during July 2014 to March 2015, 377 patients were admitted with a fractured neck of femur and went on to have surgery, only 142 were operated on within the four hour timescale from arrival into ED.109 patients had surgery over 48 hours after admission.

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

The emergency department was open 24 hours a day. Patients were requested for their consent. Staff had received training in the Mental Capacity Act (MCA) and

Deprivation of Liberty Safeguards (DOLs) in the previous 12 months. Staff had received appraisal, staff spoke to us about feeling confident about working within their competencies.

We observed good relationships between medical, nursing staff and other MDT professionals within the department.

Evidence-based care and treatment

- Departmental policies, procedures and guidelines were based on nationally recognised best practice guidance, for example National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine (CEM) standards. Current pathways were examined and were in line with recommended guidance
- In line with national best practice tariffs, the pathway in Mid Yorkshire trust is to not admit NOF or stroke patients to Dewsbury ED. Patients with these illnesses or injuries are admitted directly via ambulance into ED Pinderfields. If a patient attends ED at DDH with family or carers they are transferred to Pinderfields on diagnosis for further treatment. On reviewing incident data one patient was inappropriately transported to Dewsbury following a stroke; however staff within the ED correctly diagnosed the condition and transferred to Pinderfields promptly.
- The CEM has a range of evidence based clinical standards which all ED's should aspire to achieve to ensure that patients receive the best possible care to ensure clinical outcomes. The CEM recommends that 100% of patients who present to an ED with signs of sepsis or severe shock should receive a dose of antibiotics prior to leaving the department (ideally within 4 hours). At Dewsbury we found no evidence this audit was being completed, on reviewing incidents a patient had a delay in management of sepsis as antibiotics had not been given correctly.
- We reviewed audit conducted on sedation in adults July 2014, the CEM standard is that 100% patients have sedation records maintained, the trust audit found that the conscious sedation records were only maintained 73% of the time (69 out of 94 occasions) against the CEM standards of 100%. None of the 69 records audited were found to be completed correctly, only 25 out of 94 were correctly coded on the electronic records system. On completion of the findings and presentation in November 2014 risks were identified as: a lack of documentation; observations and patient information; and patient safety risks due to lack of consistency with regard to planning for rescue strategies. A re-audit was planned however we have no evidence this has been completed.
- We reviewed audit plans for CEM standards for mental health.
- A must do in the CQC 2014 report was to ensure there were improvements in the numbers of fractured neck of femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours. Overall in the trust during July 2014 to March 2015, 377 patients were admitted with a fractured neck of femur and went on to have surgery, only 142 were admitted within the 4 hour timescale from arrival into ED.
- At Dewsbury no patients are admitted to ED with signs of a stroke, these patients are admitted to Pinderfields.
- Cross divisional audits were carried out in record keeping, prescription charts, consent, venous thrombolic episodes (VTE), cardiac arrests, crash trolleys, controlled drugs and non-medical prescribing and nursing documentation, we asked for evidence of audits undertaken but we did not receive this data.
- Medical staff spoke to us about specific audits conducted on the Dewsbury site such as audit of head injury guidelines and CT scanning use. Medical staff told us about changes in practice and new flow charts developed as a result of the audit. Within the 3 sites a specific non-invasive ventilation audit was in progress for completion in August 2015, this audit was based on the non-invasive ventilation (NIV) guidelines from the British Thoracic Society 2008. Blood test requesting for patients with abdominal pain is also in progress.
- Staff talked to us about new pathways implemented about early pregnancy bleeding and this now being a nurse led pathway.
- We were told that the audits are presented at the clinical governance meetings; however we did not note one being presented at the Dewsbury specific meeting.
- On checking the trust guideline for the management, maintenance and safety of play equipment it was found to be a document that had not been through approval and trust sign off.

Urgent and emergency services

Pain relief

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

Nutrition and hydration

- In the 2014 survey of emergency departments, the trust performed about the same as other trusts for the question, "Were you able to get suitable food or drinks when you were in the A&E department?
- Staff told us that a member of domestic staff is available to make patients drinks and provide sandwiches. We observed a member of staff offering hot drinks and snacks to patients, via a trolley service. Staff told us this service is provided two hourly.
- Patients told us during their admission into the ED department they had been offered drinks and snacks. Snack boxes were also available for patients.
- A checklist for vulnerable patients over 60 years had been developed and offering food and drinks was highlighted for checking for this population group.

Patient outcomes

- We were supplied with evidence that the trust participated in six of the sixteen national audits undertaken by the CEM. We understand that the trust has undertaken 100% of the CEM audits since our last inspection in June 2014 and was signed up to all of the audits in 2015-2016.
- The CEM recommends that unplanned re-attendance rates within seven days for EDs should be between 1% and 5%. Dewsbury Hospital was higher than the England average on re-attendance rates to A&E July 14 to May 2015 with a re-attendance rate of 8%.
- On reviewing clinical governance meeting minutes A&E returns were discussed and reasons for re-attendance were documented e.g. discharges from other specialities, deep vein thrombosis (DVT)s, self-discharges, frequent attenders, scans, un-related episodes, exacerbation of asthma, misdiagnosis of a child and undiagnosed infection in the later three cases involved four patients and clinical deterioration of the patients were noted. The actions box on the clinical governance meeting noted was not complete so we are unaware of any actions taken.

Competent staff

- Appraisals of both medical and nursing staff were undertaken.
- The trust reported that 83% of nursing staff on the Dewsbury site had received their appraisals.
- We received information pre inspection highlighting concerns about the competence of staff.
- Staff told us that all staff was paediatric life support trained, and have attended a children's nursing course at a local university, however we saw no data to corroborate.
- Nursing staff we spoke with felt well inducted into the department and well supported, staff felt able to raise concerns when they need to. As agency use is high an induction booklet for staff on working in the ED has been developed.
- Nurse practitioners were trained to treat injury and not illness and were not nurse prescribers.
- Staff explained to us the new band 5 rotation programme between the three EDs which ensure competencies are maintained in the different pathways. As a result of the band 5 rotation scheme, plans are currently been made to rotate the band 6 and 7 roles.
- We spoke to junior doctors who told us they received regular supervision from the emergency department consultants.

- Nursing staff were aware of the need to revalidate in the coming year, however staff told us that no specific issues had been discussed with them from the management team in regards to revalidation.
- Staff we spoke with, told us they felt confident and competent working in departmental protocols. They did express concern to us that the length of stay of some patients in the ED meant that different competencies were required. On two occasions during blood transfusion audit, staff had obtained blood although their competencies were out of date by some months.

Multidisciplinary working

- There were examples of internal multi-disciplinary team (MDT) working. We observed positive relationship and engagement between the bed management team and infection prevention and control specialist nurse during attendance in the department, and of the bed manager in the management meeting.
- During our attendance at a bed management meeting we noted an organised system and process to the meeting, with key decisions been made in an effective manner. The current REAP level was discussed, the amount of patient in the ED department, the current wait time and number of breaches were discussed. Whether a hospital divert was in place was discussed and what beds were available and what extra capacity was open.
- Staff spoke to us very clearly and positively about the relationship with the newly formed mental health liaison team, this new service was provided mental health advice and guidance 24 hours, seven days a week. Staff felt this improvement in care services for mental health patients.
- Staff spoke about their positive relationships with the safeguarding team, community physiotherapy teams and medical consultant teams. Staff also spoke to us about their links into specialist nurse services in relation to stroke, respiratory and cardiac conditions.
- Staff spoke to us about the admissions avoidance team, which enabled rapid access to a GP and community matron where the aim was to get patients home safely. They also told us about the hospital avoidance team for when issues where more social in nature.
- Staff had developed a system that when they are short of nursing staff within the department, the phlebotomist service provided a member of staff to help with blood taking.
- Staff spoke to us about their relationships with the drug and alcohol liaison services and a specific teenage section of this team.
- Ambulance staff we spoke to talked about a good rapport with both medical and nursing staff.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week. Children's ED is also open 24 hours a day.

Access to information

- Medical and nursing staff could access current information for each patient in the department. This information was displayed on computer screens in the main nurse base area and touch down areas in the department.
- The computer information system had been recently introduced into the department and was widely used in the NHS.
- Staff reported to us frequent breakdowns of the national ED recording systems, no incident forms were completed, however on reviewing the communications book, computer system breakdown was noted twice in May and highlighted that patients had breached because of the breakdown.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patient's consent being requested before care was delivered.
- Staff spoke to us about their knowledge and experience of the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS), staff were aware of procedures for gaining consent and the need for referrals where required.
- Staff had accessed training on MCA level 1, 2 and 3, compliance data supplied to us by the trust showed low average levels of training compliance rates of between 67% Medical staff and 32% Nursing staff.

Urgent and emergency services

- We spoke with staff about obtaining consent from children and young people "Gillick Competency". Staff were clear about the need for assessment of children and young people under 16 to decide whether they are old enough to consent to medical treatment.

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

Requires improvement

Concerns were raised about the flow and capacity in the department we reviewed evidence of patients experiencing delays in treatments and assessments due to capacity issues within the department. The 95% target of patients waiting and being treated in the department had not been met for the previous six months. With compliance with this target being worse in the previous six months pre inspection. People were waiting for admissions longer than the four hour target and we reviewed evidence of patients waiting between 4-12 hours since attendance. A large number of staff expressed concern over the overcrowding in the department and that the department at times felt unsafe. Data supplied by the trust for the 15 minute ambulance handover times indicated that in the previous two months Dewsbury had achieved between 84-86% with the overall trust position being between 72-78%.

Access for specialist treatment was provided on site and strict admissions criteria existed. Pathways were all developed to reflect national guidance. A good system of answering complaints within the three departments was identified. Translation services were provided with evidence of doctors translating.

Service planning and delivery to meet the needs of local people

- Staff spoke to us about increased attendance, data supplied by the trust showed that attendance was relatively static with on average 7557 every month July 2014 to May 2015; peak attendance was seen in March 2015 with 8084 attendances and lowest attendance in February 2015 with 6727 attendees.
- Concerns were raised about the flow and capacity in the department, this meant that patients were now spending longer in the department and exit block and overcrowding was occurring within the ED. Staff spoke to us about not enough capacity in the ED and times of exit block. The trust acknowledged that ensuring safe nurse to patient ratios on inpatient wards had impacted on the number of beds available and therefore impacted on the delivery of the four hour standard.
- Staff spoke to us about a lack of capacity and times of exit block, when they had patients on trollies around the nursing station.
- Staff were aware of the population they serve and the ethnically diverse needs that they require.
- Staff spoke to us about their concerns about the population of the area, the population were known for not accessing medical services early enough and then attending ED, by which point the patients can be very unwell.

Meeting people's individual needs

- A dedicated paediatric area is available 24 hours a day and staff spoke to us about their preference to see children in the children's ED during the evening. This area has dedicated Paediatric ED nurses from 9am to 9.30pm. During the night this is staffed by adult only trained staff nurses, however, they have all had extended training on local paediatric ED courses.
- Selections of posters throughout the department were aimed directly at children and young people to encourage access to services.
- Access to radiology service is good with radiology being located as the next department outside of the ED.
- On the ED computer system a symbol was available to request direct to admitted ward staff that patients needed an air mattress, this system ensured that patients received one prior to admission onto the ward. Staff spoke to us about pressure area packs.
- Patients we talked to were happy with the care they received and felt they were kept informed of the decisions that were made. We witnessed a nurse explaining to patient's relatives the condition of the patient and the care delivered so far and the treatment plan going forward.
- We witnessed nursing staff being friendly and engaging to children and young people.

- Staff spoke positively about the lead nurse for dementia care services and the need for physical changes within the department to make it dementia friendly. Staff showed us stickers that were used to identify patients with dementia.
- Nursing and medical staff spoke to us about a programme called documented care, comfort, toileting and verbalising (CCTV) this programme clearly demonstrates the comfort rounds given to patients, during the inspection we saw evidence of the CCTV round.
- A 'listening to you' board had been developed as a result of the information from the friends and family test results. However some of the actions were implemented in early 2015 such as a television in the waiting area, so although feedback is being gained via the friends and family results, information shared with the public is not as current as it could be.
- Translation services were available, we observed signs translated into Urdu and Hindi were present in the bays advising only two visitors per bed.
- Family and friends cards were also found to be available in other languages.
- Staff were aware that during the time of the visit it was Ramadan and the need to support cultural needs.
- Staff spoke to us about making posters in picture and symbol formats rather than the different languages. We reviewed an incident form from March 2015 where Urdu had been spoken by the doctor to the patient to enable accurate assessment and treatment of a vulnerable patient in a domestic violence case.
- Medical staff had recently gained new skills to enable them to use ultrasound scanning and the differences this has made to patient care. They spoke to us about the innovations in DVT scanning and the fact that they are now able to scan patients in the department and diagnose clots in the legs rather than the patients having to return for scanning the following day.
- Information for patients was available with regards to domestic violence.

Access and flow

- The Mid Yorkshire hospitals NHS trust had not achieved the national target of seeing 95% of patients within four hours consistently each quarter for the previous six months ranging from 82.6% to 92.1% Jan 2015- June 2015. Dewsbury had not met the 95% target for the previous 6 months ED ranging from 86.7% to 93.6% Jan 2015- May 2015. The overall trend in recent months was getting worse with on average 220 patients breaching the 4 hour target July 2014 to November 2014, peaking at 273 in August 2014.
- Concerns were raised about the flow and capacity in the department. The trust acknowledged that ensuring safe nurse to patient ratios on inpatient wards had impacted on the number of beds available and therefore impacted on the delivery of the four hour standard. This meant within the emergency department patients were now spending longer in the department and exit block and overcrowding was occurring within the ED
- Staff told us that overall attendance at Dewsbury ED has increased by 12% we noted from, data supplied by the trust that attendance had remained relatively static.
- The CEM recommends that the time patients should wait from arrival to receiving treatment is no more than one hour we noticed in the internal communications book that on a number of occasions patients were waiting between 2- 3.5 hours for treatment, in a month long waits for documented 23 times.
- The median amount of time people could expect to spend in ED before being discharges, admitted or transferred between July 2014 and September 2014 all three sites was on average around 125 minutes. Lower than the England average of 136 minutes .However since September 2014 there have been significant changes in the flow of the department, due to the commissioning agreement.
- On average against the England comparison the percentage of people leaving the ED on all three sites was higher than the England average. Overall in England this data is recognised by the department of health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait
- There have been no reported breaches of patients waiting for more than 12 hours in the ED once a decision had been made to admit. However on several occasions in the communications book and on breach reports patients are waiting between 4 and-12 hours for

admission following the decision to admit. On the first day of our visit the waiting time was 2 hours at 9pm. Three breaches of four hours had occurred during the day ranging 4hrs 58 minutes – 7hrs 42 minutes. Reasons for the breaches were clinical, waiting for transport and waiting for diagnostics.

- Data supplied by the trust for ambulance handover times within 15 minutes indicated that in the previous two months Dewsbury had achieved between 84-86% with the overall trust position being between 72-78.%.
- Ambulance crews we spoke to talked about a complex and complicated handover process and this not being consistent over the three sites in the trust.
- Staff spoke to us about the decisions for ambulance transport bookings whether patients required immediate transfer or whether could wait in the ED until a crew was available. Staff felt that a change had occurred recently within the ambulance service and this change was impacting on patient care and patients were staying in the department longer rather than being transferred to the appropriate area.
- The nursing and medical team describe the department as "a very busy department", with the main obstacle to flow being "exit block". Exit block is where patients have received treatment and have a plan for further care however beds aren't available within the hospital; to transfer patients into, so the patient remains in ED until the bed is available. This is potentially an impact for overcrowding in an ED department.
- Staff spoke to us about ED blockages in the system and not been able to get patients discharged from the department to appropriate beds, staff told us that they were aware of times recently when had to be placed in corridors around the nurse's station on trolleys. In the communication book reference to patients in corridors was made. On reviewing incidents reports, a patient had been admitted from the ambulance service and placed into the corridor near the nurses' station due to lack of available cubicles, when the patient was transferred into a cubicle for further assessment, the patient had died and staff completed an incident form due to the lack of dignity in death. One complaint we reviewed, stated a patient was sat in a corridor on a bed in a robe.
- Staff told us that due to the increased capacity in the department they worry about being able to do a good job, they told us that sometimes they don't have enough time to make a cup of tea for some patients. Many staff spoke to us about things getting worse in the department lately in regards to patient trolley waits and getting people out of the department and admitted to beds onwards. They were unable to explain to us reasons why this was an issue. Staff spoke to us about their proudness in the team to cope and have the ability to manage patients in a very busy department.
- Staff told us that when ED gets busy and they are not able to admit patients directly to wards, patients were placed on beds in ED rather than trolleys. Staff then closed a side of the ED to make a bedded treatment area, however staff assured us that even though a patient is now on a bed the timings in ED are still recorded.
- Staff used the communal hospitals discharge lounge during its opening hours of 10am until 6pm; however this area only takes one bed bound patient. Staff had also developed their own internal discharge lounge within the ED, chairs and TV and access to drinks are available in here. This room is used for patients awaiting transport or awaiting test results.
- Initial assessment rooms are available and after triage staff used these areas for immediate treatment.
- Receptionist are available, and from 12midday receptionists are based on the main nurse base until 9.30pm, this is to help book ambulances in and to book transfers out, ambulance staff we spoke to told us the receptionist isn't always available on this desk, and when they are not a member of ambulance staff has to wait to hand over in the ED queue which delays the handover. Am
- Internal hospital diverts often occur within the trust. This is where one hospital is suffering overcrowding in the ED and transfers all admissions to another hospital in the trust. These diverts can be GP diverts from GPs in the Pinderfields area to DDH or a Blue light divert to DDH where all ambulances are diverted from Pinderfields to DDH, or vice versa. A blue light and GP divert was in place during the day of our first visit to DDH. 19 diverts had been in place during the previous

two months, on reviewing the communications book many issues were highlighted when a divert was in place and concerns were raised such as capacity, staffing and assessment and treatment time issues.

- Extra funding had recently been released until September 2015,which allowed a porter to be present in the department 10am until 10pm which staff said helped to maintain the flow and transfer of patients.
- GP medical referrals should go directly to the ward, unless the patient is clinically unwell and needs resuscitation when they will be diverted to the ED. GP surgical referrals attended the ED if there is no capacity on the surgical assessment unit. Only patients that are ambulatory can attend the ambulatory care unit following referral to themedical team.
- Staff spoke to us about clear plans for escalation and they were aware of how to ask for help when the department was busy, this included asking paediatricians to attend the department and, referrals directly to speciality areas.
- On two occasions staff documented in the communications book that the department was unsafe. The clinical site manager (CSM) was contacted, on one occasion one member of staff was sent to ED to help.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). All complaints were overseen and allocated by the matron, and investigated by four medical consultants and the three ED lead nurse.
- Complaints were submitted and processed using the trusts computer centralised recoding tool. Learning from complaints was disseminated via the combined clinical governance meeting for Pinderfields and Pontefract and the Dewsbury clinical governance meeting for Dewsbury.No formal route of learning was shared over the three sites.
- Senior nursing and medical staff spoke clearly to us about how complaints information is gained, responded to and used within the department. Complaints are investigated by four medical consultants and the lead nurses.
- Medical staff spoke to us about their knowledge of complaints and they understood the top complaints to be about miscommunication and misdiagnosis they felt that these were reasons because sometimes medical staff felt under pressure to discharge patients. A complaint we reviewed was about the attitude of medical staff and subsequent treatment such as a scan being promised, however not arranged.
- Staff spoke to us about getting feedback from complaints and gave examples to us about the need for communication with patients around waiting times for assessment and treatment.
- We reviewed 4 recent complaints and their responses; we saw that apologies where offered and clear routes of the investigation and clear timelines were documented and plans to prevent complaint happening again were noted. In the second of the three complaints duty of candour was commented on this wasn't present in none of the other three. We also reviewed minutes of the senior nurses meeting and governance minutes where complaints where discussed.
- Staff spoke to us about the induction checklist developed by the trust was based on lessons learnt from a complaint received.

Are urgent and emergency services well-led?

Requires improvement

During the inspection it was clear that staff did not understand the 2017 vision for the three emergency departments. Dewsbury patients and staff were worried for the future of their department

No robust clinical governance structure occurred through the three EDs, Pontefract and Pinderfields held meetings together and Dewsbury held a separate meeting; these meetings were not well attended by the senior management team.

The risk register had no specific risks to Dewsbury present on it. Visibility of the senior management team on the Dewsbury site was poor.

Urgent and emergency services

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

Vision and strategy for this service

- The Mid Yorkshire NHS trust had introduced a set of core values, during our discussions with staff; staff did not make reference to the values.
- Staff spoke to us about the awareness about the whole of the trusts ED's struggling with the plan for the future of this department. Staff spoke to us about people leaving because of the uncertainty of the ED services they were aware of staff leaving and staff not fulfilling offered positions. The Chief executive had recently visited Dewsbury ED to share the future plans, however staff still remained uncertain. Senior nursing staff spoke to us about recruitment being an issue due to the uncertainty of the service.
- Senior nursing staff told us the vision for the department was to streamline services within ED at Dewsbury and to enable admission of the patient into the correct place. Senior nursing staff were clear there was no trust plan to close any ED services as Dewsbury, and that life threatening conditions will still be treated on the DBH site. Senior nursing staff were aware that in the 2017 vision no intensive or coronary care services will be present on the Dewsbury site, and that more links with community services and community ambulatory care need to be planned to avoid admissions.
- Re-configuration of the Dewsbury ED was the biggest issue of staff worry list, Staff reported internal discussions in Dewsbury ED about how to reduce capacity, assumptions about their capacity about admitting medical patients, however many patients at Dewsbury attend on foot and not via ambulance so staff struggled to understand how this vision would be achieved.
- Patients we spoke to expressed concerns about the future of the ED service at Dewsbury and the possibility of losing their ED department.
- We reviewed the urgent care improvement programme which has specific detailed work for the future development of the ED and the re-launch of rapid assessment strategies and ambulance handover pathways. Key actions and performance requirements to be completed within that quarter were identified, however some status of these actions were indicated with red and amber, indicating that not all actions had been completed within the timescales.

Governance, risk management and quality measurement

- A clinical governance structure was in place on the Dewsbury ED site, as ED was part of the division of medicine their governance meetings fed into the division of medicine governance meeting.
- No robust governance structure existed for the three EDs within the trust. A computer programme was shared to store their governance minutes, but no formal mechanism existed for shared governance on all three sites.
- The ED held multi-disciplinary group governance meetings, incidents, complaints, appreciations, clinical issues, complaints, and near misses and root cause analysis, clinical audit data were reported however little narrative was available about discussions or actions. And on Dewsbury site are discussed. Minutes from the joint Pontefract and Pinderfields Governance meetings were not discussed. Actions boxes were also not complete. Actions agreed had been noted for the three meetings (a six month timescale) with no apparent progress e.g. Doctors induction document, deaths in department, overdose blood tests.
- We reviewed three sets of minutes and medical staff attended; apologies were received from the lead nurse and one medical staff. Attendance was poor; the lead nurse, the head of service (HoC) had not attended all the meetings reviewed.
- The consultant body at Dewsbury held their own Consultant meetings, again no opportunity existed for all consultants on all sites to come together for joint meetings.
- Staff reported that their relationship with senior clinical staff at Pinderfields was good.
- Senior nursing staff met regularly from all three sites to discuss issues and concerns.
- A departmental covering all 3 sites risk register was available this had 8 cross site risks on it, but none specifically for Dewsbury, despite the specific risks around the patient environment.

Leadership of service

- The three ED sites in the trust was headed by a Head of Service (head of service (HoC)), a matron and a patient services manager, these staff were all based on the Pinderfields site the We heard from both the HoC and staff at Dewsbury that the HoC doesn't get to attend the Dewsbury site often, however staff did report having contact with her, and attending complaints meetings. The HoC role is 50% clinical and 50% non-clinical.
- The Matron for the service attends Dewsbury site one week in four, this is also when the matron covers the whole of Dewsbury as site matron, the matron was aware of visibility being an issue when covering a three site ED. Each of the three sites had a lead nurse and a lead paediatric nurse was available for all three sites.
- Staff told onsite management team were supportive, open, and approachable and provided good leadership. The lead nurse for ED carries a staffing bleep (which means they have to deal with staffing issues within the hospital) for Dewsbury twice a week, a role which takes them away from the ED department.
- Lead roles for key services are developed within the ED however further development is being hampered by the staffing levels, meaning that senior nursing staff often have to have a role delivering patient care, rather than being able to develop the service and improve clinical practice and knowledge.

Culture within the service

- We found there was an open culture in the ED and staff were not afraid to express concerns informally or formally.
- Staff spoke to us about the ED team and expressed appreciation and affection for their colleagues from all levels and grades of staff
- Staff reported to us a previous poor working relationship with Pinderfields hospital and a' them and us' situation, some staff called Pinderfields "the mother ship", however staff did say due to the band 5 rotation scheme this relationship is now getting better.
- Staff spoke to us about their ability as a department to be flexible to the needs of the patients and accommodating the increased turnover, acuity and length of stay of the patients.
- Senior nursing staff told us they feel supported in their role and decisions are always taken as a triumvate.

Medical care (including older people's care)

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides medical care (including older people's care) across three sites including Dewsbury District Hospital. Dewsbury District Hospital had eight medical wards, including a medical assessment unit (MAU/ward 11), a coronary care unit (CCU) and a short stay medical unit (SSU/ward 10). The medical wards at Dewsbury covered a number of different specialties, including general medicine, care of the elderly, cardiology, respiratory, gastroenterology, neurology and Stroke care.

We spoke with patients and relatives, doctors, nursing staff, therapists, pharmacists and ward managers. We looked at the care records of patients and prescription charts. We visited SSU/ward 10, MAU/ward 11, ward 2, ward 4, ward 8 and the discharge lounge, and carried out observations on the areas we visited. Before the inspection, we reviewed performance information from and about the trust.

In July 2014 CQC carried out an announced comprehensive inspection and overall we rated medical care as requires improvement. We rated safe as inadequate and improvements were required for effectiveness, being responsive and well-led. We found caring to be good.

Summary of findings

Overall we rated the safety domain as requires improvement. We had concerns regarding the registered nurse staffing levels particularly on the wards. There were infection control issues identified which included equipment not being appropriately cleaned, staff not appropriately following infection control procedures and poor hand hygiene. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples on how they had learnt from incidents and how improvements were implemented.

Overall we rated medical services as requires improvement for being effective. Throughout our inspections we found patients were not always monitored or supported with their nutrition and hydration needs. We found assessments and records were not always fully completed. We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal.

Overall we rated medical care services as good for caring. Generally patients and relatives stated they had experienced very good care. Patients told us on the whole buzzers were answered quickly; we noted this whilst on the wards. However some patients told us they had not experienced good care whilst on the wards.

Medical care (including older people's care)

Overall we rated medical services as being good for the responsive domain. We found the number of medical outliers had reduced on surgical wards since our last inspection in July 2014. We found the service had specialist roles to support people's individual needs which included a learning disability nurse and link nurses for dementia. There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Overall we rated medical care services as requires improvement for being well-led. There was a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than on hospital site. Staff told us the matrons were visible and supportive they told us a matron was usually 'on site' at Dewsbury Monday to Friday. However some staff said they wouldn't know who the senior managers of the division were or trust board executives.

Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Senior staff told us that each Friday they held a conference call to discuss risks across the division. Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.

Are medical care services safe?

Requires improvement

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

There were infection control issues identified which included equipment not being appropriately cleaned, staff not appropriately following infection control procedures and poor hand hygiene.

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

Incidents

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

- Staff told us they knew how to report incidents on the trust's datix system and usually received feedback from these.
- Senior nurses told us incidents and complaints were summarised in a newsletter. We saw this displayed in the staff room on wards we visited.
- Managers told us on the short stay unit (SSU) they had a verbal patient safety brief each morning at handover and that the trust safety bulletins were placed in a file for all staff to read. Staff we spoke with confirmed this process.
- We were told within the hospital site there was a ward manager network and this was used for sharing learning from incidents. A manager told us they had worked closely with the governance team when investigating incidents and gave two examples of incidents that they had been involved in and how these were appropriated, reported, escalated, investigated and lessons shared.
- Some staff on told us they were not aware of the never event involving methotrexate that had occurred within the division of medicine.

Duty of Candour

- The duty of candour regulation ensures that providers are open and transparent with people who use services in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- Most staff told us they were aware of the Duty of Candour regulation. A ward manager was able to detail the 'requirements of duty of candour and gave an example of how this has been used in practice recently. However some staff told us they were unaware of the duty of candour regulation.

Safety thermometer

- The NHS Safety Thermometer was 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 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, and had developed venous thromboembolism or urinary infections in patients with catheters.
- We saw safety thermometer information was displayed on the communication boards on the wards we visited.
- Safety thermometer data for the SSU indicated that the unit's last fall with harm had occurred in July 2014, the last incident of Clostridium Difficile Infection was in April 2015, the last MRSA bacteraemia was in June 2013 and the last grade 3 or 4 pressure ulcer was on 14th February 2015. An action plan was created following the pressure ulcer.
- Staff we spoke with told us staff received feedback relating to the safety thermometer data for their ward.
- Senior nurses and staff on the MAU told us the ward had 2 months of harm free care.
- On ward 4 the information displayed indicated that last category 3 or 4 pressure ulcer had occurred in April 2014. The last fall with harm was in December 2014. There had not been any catheter acquired urinary tract infection (CAUTI's) or MRSA bacteraemia. The last case of clostridium difficile infection had been in January 2015. A senior nurse on the ward told us that they had had 23 harm free days and only one fall in June 2015. This was attributed to the introduction of a 'buzzer nurse', the use of safety guardians and sensor care equipment.
- We saw information which indicated there had been 12 falls in May 2015 and six falls in June 2015 on ward 2. The ward had also had two pressure ulcers. Staff told us to support patients and staff on the ward safety guardians were used to help prevent falls.
- On ward 6 we saw information indicated that the ward had a newly developed category 3 or 4 pressure ulcer and a complaint had been received in May 2015. The nurse in charge on the day of our inspection was not aware of these incidents.

Cleanliness, infection control and hygiene

- There were policies and procedures in place to ensure that any patients with an infection were managed appropriately, including barrier nursing procedures where applicable.
- We saw information that indicated routine Methicillin-resistant Staphylococcus aureus (MRSA) screening on SSU had fallen from 100% to 75%. Senior nurses told us that an action plan had been put in place to address this issue. We saw there was also a slight fall in screening on MAU from 100% to 98.9%.
- On 25 June 2015 we saw on the SSU three pieces of equipment without 'clean' stickers in place. We also

noted one piece of equipment with a 'clean' sticker in place that was dated 22/06/2015 at 04:30am. This was a piece of equipment that was in use at the time of the inspection.

- We noted three isolation rooms with the doors open. These rooms were highlighted with the use of an infection prevention and control poster which stated that the door should be closed.
- During the inspection we saw in one of the patient bays that access to a hand washing sink was restricted due to clutter which included a wet floor cone, a portable computer station and two footstools.
- We observed one nurse who had entered a side room with a patient who had an infection without the use of personal protective equipment. We observed the nurse on leaving the room used hand gel to clean their hands.
- We found on ward 2 there were six side rooms occupied by patients with infections. We were told there were four patients who had community acquired MRSA, one patient had E-coli and one patient had Clostridium difficile infection.
- We saw on ward 2 there was urine stains on the toilet seat and a toilet brush which was out of date in the toilet closest to the nurse's station. In addition to this we saw a seat raiser which was stained with urine and faeces in a shower room.

Environment and equipment

- In all areas staff described the process for checking the servicing data on medical devices. We were told that servicing was completed by the Medical Physics Department. Staff told us that each piece of equipment had a label which indicated the date of the last service and the due date for the next service.
- On all wards we saw medical devices without appropriate evidence of servicing. This included equipment without service stickers and some which had an expired service date. We also saw some equipment with in date service stickers. All equipment had an asset number and some had a red, green or yellow sticker with a tick symbol. Staff told us that they were not aware of the purpose of the tick stickers.
- We also spoke with the manager of the medical physics department who advised that a new process had been implemented four years ago. They told us that the new system involved all equipment being logged on a data base and engineers visited the wards and serviced the equipment and that stickers were no longer used.
- None of the staff that we spoke to told us that were aware of this. This would indicate that staff on wards were not aware of the change in the servicing of equipment and would not know if there was equipment which was outside of its service date.
- We checked resuscitation equipment and found that daily checks had been completed on the discharge lounge, MAU, SSU and wards 2 and 4 at the Hospital.
- On ward 2 we saw a picture of the trust board displayed and a poster showing the various staff uniforms. We also saw large pictures, toilet signs on doors and clocks, which are recommended for patients with dementia, in use on ward 2.

Medicines

- Staff on MAU told us they had experienced problems accessing medications for patients. This had improved with the introduction of a TTO (tablets to take home) cupboard. The hospital had an on call pharmacist service and also an emergency cupboard which could be accessed by the senior nurse on site.
- Staff on the SSU told us about the process for TTO's. This involved staff checking that patients had a two week supply of their medications at home. However the ward manager told us on occasions it was difficult for two staff to check TTO's because of staffing levels on the ward.
- We visited the discharge lounge in the hospital. Staff on the unit told us one nurse checked the medications for discharge. For one patient we found they had medications that they had brought in to hospital (in 3 dossett packs) plus medications in boxes that had been used on a previous ward. In addition to this we were informed a relative was collecting new dossett packs from an external pharmacist and the patient was waiting for new medications from the hospital pharmacy. We were concerned that the patient may have had too many of some medications and changes made to medications whilst in hospital maybe missed.
- Staff told us that time specific medications for example Parkinson's disease medication were prioritised and systems were in place to ensure that these were administered timely.
- The manager from MAU was able to explain the lessons learned and actions implemented following a never event which related to methotrexate. Staff on MAU also told us that they were made aware of incidents relating to medications this included the never event.

- We checked the daily drug fridge temperature recordings on the MAU and found that the temperature had been recorded daily. Temperatures for June had been consistently between 2 and 8 degrees centigrade.
- We checked the drug fridge temperature recordings on the SSU. The temperatures had been recorded daily but we found that on 17 days in June the temperatures were recorded as above 8 degrees centigrade. Staff told us that these results should have been acted upon but that there was no evidence that this had happened.
- We were told later the fridge was being remotely monitored by the pharmacy and that the temperature recording throughout June had been within the normal ranges except for two occasions and these were attributed to times when the fridge door had been opened.
- On ward 4 we saw that drug fridge temperatures had been recorded daily in June. Temperatures had been recorded as being between 2 and 8 degrees centigrade every day except one when the temperature had been above 8 degrees. There was no evidence that any action had been taken on that occasion. We spoke to a senior nurse who confirmed that they were not aware of the incident and there was no evidence of a remote monitor inside the fridge.
- The lock on the drugs fridge door on Ward 2 was broken and staff informed us it had been reported on the day of our inspection.
- We saw evidence that controlled drug were completed in line with policy by staff and pharmacy staff. Separate controlled drugs registers were in place for ward and patients own medications.
- Staff on the SSU told us that there had been a lot of change in relation to pharmacist provision since the last inspection, there was a greater presence on the ward, more audits which included controlled drug checks had been completed. Staff on the MAU told us that a pharmacy technician visited the ward twice a week whereas staff on ward 4 told us that the ward did not receive 'much' support from a pharmacist but that a pharmacy technician attended the ward once or twice a week.
- We reviewed medication charts on wards 2, 4 and 8 and found medication reconciliation had taken place with 48 hours except for one patient who had been on the ward less than 48 hours. We found in all the medication charts there were no gaps or omissions in administration recordings.
- We found patients with oxygen prescribed had this correctly documented in their notes and on their medication chart.

Records

- We reviewed 27 records across the medical wards and found records were completed appropriately these included intentional rounding documentation, pressure ulcer care plans and support with position changes and falls assessments.
- The trust had introduced hourly rounding's on wards, 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 evidence of the rounding charts in use on the wards we visited.
- On ward 8 we looked at 6 sets of nursing records.
- All patients had a Malnutrition Universal Screening Tool (MUST) completed and those at risk had a nutritional care plan.
- All records had pain assessment tools and pain scores had been completed regularly
- Four patients were identified through assessment as being at risk of falls and care plans had been implemented. Two patients were not at risk
- All six patients were at risk of pressure ulcers. Assessment had been completed and regular turns were documented.
- We looked at nine sets nursing records on ward 4. We found that food and fluid charts were completed. Intentional rounding charts were in place and had been completed hourly. Risk assessments were also completed.
- On the Medical Admissions Unit completion of fluid balance charts was poor after 2pm for the previous day. One chart did not evidence any oral intake for the day of inspection (pre 11:00am) One elderly patient having intravenous fluid did not have any evidence any oral fluid intake.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.

- We saw information for June 2015 which showed 100% of staff had received level one safeguarding adult training and 80% had undertaken level two training.
- For the same month we saw 100% had completed level one children's safeguarding training and 81% had completed level two.

Mandatory training.

- The trust provided information on training which showed compliance rates within the division of medicine. We saw there was 88% compliance with core mandatory training this included training on health and safety, fire safety, infection control and manual handling.
- The ward manager on MAU told us they had checked the mandatory training records and found that the band 6 sisters had maintained this in the absence of a band 7 and that all staff had attended or had booked places for statutory mandatory training.
- We were told that mandatory training compliance for staff on the SSU was 75%. The ward was being supported by a matron to ensure plans were in place to address gaps in training and that most staff had places booked for training. We were also told that there were delays in updating the training data base which led to discrepancies in the percentages of staff trained.
- On ward 2 we saw ward based information which showed that only five out of 28 staff had completed practical moving and handling training and seven out of 16 ad completed resuscitation training.

Assessing and responding to patient risk

- We saw fall risk assessments completed within care records and the trust had implemented the use of Safety Guardians to try and reduce the incidence of falls. Safety Guardians on the wards provide one to one observation and interaction with patients who are at high risk of falls. Safety Guardians are care workers provided by a local agency, and are trained to provide distraction to and observation of patients identified as being at increased risk of falls due to dementia/delirium.
- A display board at the entrance to Ward 2 contained information on You told us/We did. For example
  - You told us - Reduce patient falls. We did – Use safety guardians to provide 1 to 1 care.
- On ward 4 a senior nurse told us that the team considered and tried to address all recommendations received from service users. We saw this demonstrated on the communication board. The service user recommendations and actions for May 2015 were displayed as follows:
  - 'Quicker response needed for buzzers' →Staff told us that a 'buzzer nurse' had been introduced. This role was allocated to one of the HCA's on duty each day. 2 HCA's would be responsible for caring for the service users who needed the assistance of 2 and the 3rd would be the buzzer nurse – assisting more independent service users and responding to buzzers.
- Ward 4 also had safety guardians on each shift and sensor care equipment had been implemented to reduce falls.
- We saw information which indicated there had been 12 falls in May 2015 and six falls in June 2015 on ward 2. The ward had also had two pressure ulcers. Staff told us to support patients and staff on the ward safety guardians were used to help prevent falls.

Nursing staffing

SSU Ward 10

- On the SSU at we were told that the planned staffing levels on day shifts were five registered nurses (RN's) and three health care assistants (HCA's). Staff told us the levels were rarely met and the actual staffing was predominantly three or four RN's and two HCA's. At night the planned staffing was three RN's and two HCA's.
- We reviewed the staffing roster for the week 1 June 2015 it showed that minimum RN staffing levels were not achieved throughout the seven day period with only two RN's on duty on three days. There was no evidence of agency or bank staff on the roster.
- Agency usage on SSU was reported at approximately 20%. We were told that most of the agency staff was familiar with the ward. Staff told us as many as 30 incident reports was submitted each month in relation to staffing.
- A senior nurse told us that carrying the 'staffing bleep' took staff away from the ward which resulted in further concern about staffing. We were told that this had been escalated to the Matron.
- We were told on the SSU there was one whole time equivalent (wte) band 6 and 4.7 wte band 5 vacancies.

- A member of staff on the SSU told us that staff received a handover for the caseload of patients that they would be responsible for and that the coordinator received a full handover.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 70.3% for unregistered nurses it was 68.7%. The fill rate for night shifts was 96.1% for registered nurses and for unregistered nurses it was 93.5%.
- In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts the fill rate for registered nurses was 71.6% for unregistered nurses it was 77%. The fill rate for night shifts was 97.2% for registered nurses and for unregistered nurses it was 100.3%.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 75.7% for unregistered nurses it was 72.9%. The fill rate for night shifts was 97% for registered nurses and for unregistered nurses it was 89.5%.

MAU Ward 11

- The MAU had 28 beds the planned RN staffing ratio was one nurse to seven patients therefore the optimum staffing levels were five RN's and four HCA's. The ward manager role was supervisory, staff told us when optimum levels were achieved staff would sometimes be moved.
- On the MAU concerns were escalated when staffing levels fell below the safe minimum. The 'Safe Care System' acuity tool was used within the trust. We were told that the system was effective and that the tool enabled the nurse in charge to assess and plan staffing levels.
- On MAU staff told us that the coordinator for the unit received a full ward handover and patient safety brief. The remaining RN's received a handover for half of the ward.
- On the day of inspection the staffing levels on the MAU was four RN's and two HCA's on the morning. At lunchtime we were told that the numbers would drop to four RN's and one HCA. We were told that an RN had been moved to SSU to cover shortages..
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 73.8% for unregistered nurses it was 79.1%. The fill rate for night shifts was 91.1% for registered nurses and for unregistered nurses it was 93.5%.
- In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts the fill rate for registered nurses was 81.1% for unregistered nurses it was 73.8%. The fill rate for night shifts was 95.7% for registered nurses and for unregistered nurses it was 86.2%.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 82.9% for unregistered nurses it was 88.6%. The fill rate for night shifts was 95.7% for registered nurses and for unregistered nurses it was 90.2%.

Ward 2

- On Ward 2 there were three registered nurses on duty to care for 32 patients. A nurse told us that earlier on that day four registered nurses has been available and one had been moved to another ward. This meant the nurse to patient ratio was one nurse to 11 patients.
- A notice board on ward 2 displayed safe staffing information. The planned level of staffing for the day shift was four registered nurses and three health care assistants and the actual was three registered nurses and four health care assistants.
- Staff told us that every time the ward has four registered nurses on duty one would be taken off them to work elsewhere. Some staff told us that staffing 'felt worse than last year'.
- We were told that recruitment is being managed monthly by the trust and that the downgrading of the Dewsbury site was causing problems with recruitment. There was a band 7 vacancy and three registered nurse vacancies on ward 2.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 85% for unregistered nurses it was 89.2%. The fill rate for night shifts was 98.7% for registered nurses and for unregistered nurses it was 105.3%.
- In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts

the fill rate for registered nurses was 83.7% for unregistered nurses it was 90.2%. The fill rate for night shifts was 100.8% for registered nurses and for unregistered nurses it was 79.5%.

- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 87.4% for unregistered nurses it was 91.8%. The fill rate for night shifts was 99.8% for registered nurses and for unregistered nurses it was 105.5%.

Ward 4

- On ward 4 we spoke to a senior nurse who told us the recommended safe staffing levels were four RN's and three HCA's on day shifts. On the day of the inspection there were three RN's and two HCA's on duty.
- Staff told us when four RN's were on duty one might be moved to a different ward. We were advised that in order to ensure patient safety a safety guardian was on duty each day.
- There were two wte HCA vacancies and four wte RN vacancies on ward 4. All but one of the RN posts had been recruited to and staff were waiting to start.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 81.8% for unregistered nurses it was 86.4%. The fill rate for night shifts was 95.8% for registered nurses and for unregistered nurses it was 116.6%.
- In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts the fill rate for registered nurses was 83.7% for unregistered nurses it was 101.7%. The fill rate for night shifts was 89.7% for registered nurses and for unregistered nurses it was 113.1%.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 81.4% for unregistered nurses it was 85.7%. The fill rate for night shifts was 93.8% for registered nurses and for unregistered nurses it was 95.4%.

Ward 8

- Staff on ward 8 told us that they are always understaffed with nearly every shift short of one RN and one HCA. Staff on ward 8 told us that when they were fully staffed a staff member was moved even if the ward acuity was high with several NIV patients.
- Staff including senior staff told us the one nurse to two patient ratios for non-invasive ventilation (NIV) patients was not met on ward 8 and they often had three NIV patients in a bay with other patients.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 79.3% for unregistered nurses it was 87.1%. The fill rate for night shifts was 98.3% for registered nurses and for unregistered nurses it was 100.4%.
- In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts the fill rate for registered nurses was 79.2% for unregistered nurses it was 92.1%. The fill rate for night shifts was 95.2% for registered nurses and for unregistered nurses it was 134.6%.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 89.5% for unregistered nurses it was 71.2%. The fill rate for night shifts was 97.9% for registered nurses and for unregistered nurses it was 119.1%.

Medical staffing

- The trust provided information prior to the inspection which showed that in January 2015 there was a vacancy rate of 11.56% in diabetes and 14.81% in respiratory medicine
- A senior nurse on the MAU advised that increased numbers of Advanced Nurse Practitioners (ANPs) would be beneficial within the medical division to support medical staff on the wards.
- Junior staff told us that medical staffing was 'good' and that senior staff were accessible however medical staff on the MAU felt that ward cover would be compromised when the medical team were on call for MAU.

Please include additional subheadings if needed.

Are medical care services effective?

Requires improvement

Overall we rated medical services as requires improvement for being effective. Throughout our

inspections we found patients were not always monitored or supported with their nutrition and hydration needs. We found assessments and records were not always fully completed.

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

Evidence-based care and treatment

- We saw the division of medicine for 2014-15 were participating in 25 audits. We saw the trust wide annual audit priority programme identified when the audit was due to start and when the audit was due for completion.
- For example we saw the division were participating in a national audit of adult patients who were receiving non-invasive ventilation this was due to be completed in May 2015.
- Within cardiology and respiratory medicine the service had participated in a national audit of the British Thoracic society and care of patients with COPD (chronic obstructive pulmonary disease). At the time of inspection the service were waiting for the publication of the national report and local summary.
- Staff on wards told us the band 7 completed local audits however staff said that they did not receive feedback from audits

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. Staff told us they were able to provide sandwiches out of hours. We saw evidence that protected mealtimes were observed.
- 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 were told by staff that malnutrition universal screening tool (MUST) was not always completed due to a lack of equipment being available to weigh patients
- One visitor told us ward staff left a sandwich still in its packaging next to their relative who had dementia. Their relative was unable to open the packaging and had therefore did not have anything to eat. They also said that several times their relative had been given an energy drink in a flavour they didn't like.
- On ward 2 we saw completion of fluid balance charts was poor after 2pm the previous day. We saw one chart did not evidence any oral intake for the day of inspection (pre 11:00am) One elderly patient having intravenous fluid did not have any evidence any oral fluid intake.

Competent staff

- There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. Appraisal rates for staff on MAU were 100%. On ward 4 we were told that 33 of 38 staff had an up to date appraisal, the remaining five staff had a date booked for this to take place
- One nurse told us that they qualified nine months ago and was on a preceptorship programme which included one day's training a month for a year.
- A Band 5 competency framework had been introduced trust wide. This would be supported by clinical educators and practice learning facilitators. The service was waiting the start dates for staff to participate in this.
- Staff told us HCA's were completing 'Care Certificates' and that a band 2 competency framework had been rolled out which included pressure ulcer prevention training and assessment by the Tissue viability nurses.

Multidisciplinary working

- Staff on ward 4 reported that a multi-disciplinary team (MDT) meeting took place every day at 09:15am. All patients were discussed and goal setting was included. In addition to this estimated discharge dates were set. Staff felt that MDT worked well together and that joint working was beneficial. MDT meetings also took place on MAU, ward 8, ward 2 and ward 4.
- A visitor told us they had been invited to and attended a multidisciplinary meeting regarding their relative. During this meeting they had been told that their relative would have to wait months for rehabilitation/ physiotherapy.
- We observed a ward round on ward 6. We saw the ward round did not include members of the multi-disciplinary team. Nursing staff told us they were unable to join the ward round due to staffing constraints.

Medical care (including older people's care)

- Staff told us that a weekly MDT with nursing staff, therapists and social workers took place. Staff said that it would be beneficial if this happened more frequently. Staff said nurses were unable to join the ward round due to staffing constraints

Seven-day services

- Nursing staff on the SSU reported that there was only a skeleton service from allied health professionals (AHP's) e.g. Physiotherapists and Occupational Therapists, at weekends and that this affected the flow of patients from the unit.
- We were told that a respiratory physiotherapist was on call at weekends but they were also expected to see discharges as well as respiratory patients. We were told that because the service was stretched they saw the acute patients first but they could not always see the rehabilitation patients.
- Staff told us they felt they would be able to get more patients home if physiotherapists were able to see the rehabilitation patients at the weekend.
- Staff said that patients were often left in bed on a weekend because they needed hoisting and that rehabilitation assistants were employed by the ward were often used as Health Care Assistants.
- We were told that 7 day services had been implemented without additional investment.
- On ward 8 they utilised the critical care outreach team for NIV patients. Staff told us that the team were responsive to reviewing patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- The trust provided information for the division of medicine which showed levels of training for MCA/ DOLS. We saw 83% of staff had completed level 1, 44% had completed level 2 and 59% had completed level 3 training.
- Staff on ward 4 reported that a multi-disciplinary team (MDT) meeting took place every day at 09:15am. All patients were discussed and goal setting was included. All patients with deprivation of liberty safeguarding authorisations (DoLS) were highlighted and discussed.
- At a focus group meeting of Allied Health Professionals (AHP's) we were told that training for MCA was being prioritised. An Occupational Therapist (OT) was completing level 3 training and the OT department had offered to lead on this.
- Staff we spoke with was able to demonstrate clear understanding of the Mental Capacity Act and how they would complete a DoLS assessment.

Are medical care services caring?

Good

Overall we rated medical care services as good for caring. Generally patients and relatives stated they had experienced very good care. Patients told us on the whole buzzers were answered quickly; we noted this whilst on the wards. However some patients told us they had not experienced good care whilst on the wards.

Compassionate care.

- As part of our inspection, we observed care on the medical wards and observed staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services in the division of medicine.
- We spoke to two patients who told us they had not had any problems with the care they had received.
- Patients told us on the whole buzzers were answered quickly, we noted this whilst on the wards.
- On the MAU we saw on the communication board evidence of friends and family response cards were completed for 25% of service users. These showed that, in the last 6 months, on average 95% of service users would be likely or extremely likely to recommend the service.
- On SSU there was a response rate of 29.4% for friends and family test. We saw 92% of those completed showed that service users were likely or extremely likely to recommend the service.
- A notice board on Ward 2 displayed the results of the Friends and Family test. In May there had been a 33% response rate with a score of 92% of patients who would recommend the service they have received to friends and family who need similar treatment or care.
- On the communication board displayed at the entrance to MAU we saw a 'You told us & improvements made' section which highlighted:
  - 'Long waits in A&E → Focus on early discharge to improve patient flow'
  - 'Long waits to see a doctor → Earlier ward rounds'

- 'Noisy →Try hard to reduce noise levels especially at night'

- On ward 4 a senior nurse told us that the team considered and tried to address all recommendations received from service users. We saw this demonstrated on the communication board. The service user recommendations and actions for May 2015 were displayed as follows:
  - 'Not much food choice' → Menus reintroduced. Staff explained that these had previously been withdrawn but were reintroduced for patients to ensure choices were available.
  - 'Quicker response needed for buzzers' →Staff told us that a 'buzzer nurse' had been introduced. This role was allocated to one of the HCA's on duty each day. Two HCA's would be responsible for caring for the service users who needed the assistance and the 3rd would be the buzzer nurse assisting more independent service users and responding to buzzers.
  - 'Ward lay out could be better' → we were told that that when services were reconfigured ward 4 would be staying at the Dewsbury site. The new ward area would be more appropriate to the service user needs. So whilst it was not possible to address this at present staff were able to communicate this.
  - 'No mirrors in bathrooms' → Estates were contacted and mirrors had been fitted in bathrooms.
- One relative said they would not recommend Ward 2 and were not impressed with the care provided. They said the nurses had a poor attitude and no compassion. Their relative had been assisted onto the commode and asked to press the buzzer when they had finished, because the patient had dementia they were not able to follow the instructions and therefore stayed on the commode for a long period of time.
- We spoke to a patient and three relatives on ward 2. They told us they had experienced very good care. They told us that they had been on ward 2 two years ago and it had been 'really awful' but this time it was really good. They told us that they liked the idea of safety guardians.
- We spoke to 4 patients on ward 8. All of the patients were happy with the care provided. They told us they were 'very happy with the care' and 'couldn't fault the ward just they are very short staffed'
- One patient on ward 6 told us they were happy with their care "all staff are lovely. They get by with what they can and are very short staffed." However another patient told us they were very unhappy with the care they had received stating 'they always had to wait for the toilet "they take you when they can but they are too short staffed,"

Understanding and involvement of patients and those close to them.

- We spoke to two patients on the SSU at Dewsbury Hospital both people said that they had not discussed their care with staff. One patient reported that the doctors 'don't give enough time to ask questions but I get more from the nurses if I ask'

Emotional support

- We spoke to a relative on Ward 4 at Dewsbury Hospital. They told us the staff on ward 4 were inspirational. The relative told us that their son had suffered a stroke in February 2015 and then her husband had needed surgery six weeks prior to our inspection. They said they had asked for their husband to be cared for at Dewsbury after witnessing the care received by their son earlier in the year.
- The relative said that 'miracles happen here' and that staff treated everyone like family. They told us they had witnessed everyone being treated the same, welcomed with open arms and supported.
- Another relative reported they had been supported by other relatives and staff on ward 4 and that they were happy with their mothers care.

Are medical care services responsive?

Good

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

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

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

Access and flow.

Medical care (including older people's care)

- At our inspection in July 2014 medical staff told us there were often 20 to 30 medical patients (outliers) on the surgical wards. At this inspection we reviewed data which showed from 1 June to 11 July 2015 indicated that the number of medical outliers on any one day ranged from five to 35.
- We reviewed information the trust provided between February 2015 to May 2015 that was taken as a "snapshot" once a week on a Thursday. The data showed that at Dewsbury there was between three and 14 patients admitted under a medical specialty based on a surgical ward.
- We saw information within the pre-inspection document that between July 2014 and November 2014 referral to treatment times for medical specialities were consistently between 95%-100%. Operational standards were that 90 per cent of admitted patients should start consultant-led treatment within 18 weeks of referral.
- We were told the average length of staff on MAU was 24 – 48 hours but that some patients remained on the unit for up to 4 days due to bed shortages elsewhere in the trust.
- Staff told us that sometimes the MAU was used like an A&E and that patients were also transferred from A&E to avoid breaches and also to await transport. Staff told us the unit had between one and 34 admissions per day.

Meeting people's individual needs.

- We found within the trust there was a Learning Disability Liaison nurse. We saw during our inspection a notice board in the corridor of A2 which displayed the contact details and a photograph of the Learning Disability Liaison nurse. Staff on Gate 41 told us they were aware of the Learning Disability Liaison nurse and knew how to contact them.
- Within the trust vulnerable inpatient cards (VIP) were used. The VIP card holds information about patients, which helped staff when patients sought medical help. The VIP card could be used in all the hospitals by anyone with a learning disability.
- Staff on the MAU told us that a dementia support worker visited the ward; they told us dementia screening was undertaken by the support workers. One member of staff gave an account of the dementia support worker visiting a service user with dementia who was unable to verbalise and how singing had been used to communicate.
- Staff on all wards visited at Dewsbury Hospital told us that they used forget me not for dementia and VIP for service users with learning disabilities.
- A nurse told us there was a dementia lead on Ward 2; they said it was difficult to find time to implement the improvements for patients with dementia as the ward is so busy.
- On ward 2 on the information board we saw you told us to improve the environment for patients with cognitive issues such as dementia, and we did information the ward had implemented the forget-me-not scheme, provided extra seating in the corridor, and large clocks and pictures around the ward.
- One relative told us that there is no television or anything to provide stimulation to patients with dementia on ward 2. They had brought their own radio to play music to the patient.
- A staff member on SSU at told us they felt there was not enough awareness about dementia. They told us that they used 'Forget me not' on the unit. We saw evidence of this in the form of laminated 'forget me nots' displayed above service users beds. A staff member advised that they did not feel that this was always appropriate in the ward area as this could highlight vulnerable people to other service users and visitors
- We were told that staff had access to information in other languages and to interpreters.

Learning from complaints and concerns.

- We saw in the governance, patient harm and patient experience report across the division of medicine between January 2015 and March 2015 there was 132 formal complaints and 17 informal complaints. The top key reasons for complaints was due to clinical treatment with the sub factors under this heading being poor nursing care, co-ordination of treatment and delay in diagnosis.
- In subsequent reports we saw the information for April and May 2015. There had been 40 complaints in April 2015 and 33 complaints in May 2015. The reasons for complaints were identified as clinical treatment, admissions/transfers/discharge procedure, communication and staff attitude/behaviour.
- Most staff told us learning from complaints were shared at team meeting however some staff told us they did not receive feedback following complaints

Medical care (including older people's care)

- A ward manager was able to detail the 'Duty of Candour' and gave an example of how this has been used in practice recently. She discussed this in relation to a complaint that she had been involved with.

Are medical care services well-led?

Requires improvement

Overall we rated medical care services as requires improvement for being well-led. There was a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than on hospital site.

Staff told us the matrons were visible and supportive they told us a matron was usually 'on site' at Dewsbury Monday to Friday. However some staff said they wouldn't know who the senior managers of the division were or trust board executives.

Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Senior staff told us that each Friday they held a conference call to discuss risks across the division.

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

Governance, risk management and quality measurement

- Throughout the inspections we found nurse staffing levels on wards continued to be a problem. We saw information in the governance, patient harm and patient experience report for the division of medicine which showed there had been 469 reported incidents related to staffing between January to March 2015. In the reports for June and July 2015 we found in April 2015 there had been 129 incidents and 181 incidents in May 2015 related to staffing levels.
- Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.
- We found in the minutes of the governance meeting from February 2015 it was noted there was an overdue rate of clinical incidents which related to over 300 cases and this number had increased in the latter weeks of January 2015 mainly due to clinical pressures preventing staff from completing investigations in a timely manner. The trust reported at the time of inspection in June 2015 the division had recovered their position and the overdue rate was down to 66 incidents, which was within the accepted tolerance level by the Trust.
- Senior staff told us that each Friday they held a conference call to discuss risks across the division.
- We were told that ward 2 was on the risk register due to there being 8 vacancies on the ward plus sickness and maternity. This equated to a 42% reduction in staffing. There was a proposal to move ward 2 to ward 5 this would result in the loss of five beds but the ward layout would be much improved.

Leadership of service

- There was a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than on hospital site.
- The ward manager of the MAU had recently redeployed from Pinderfields Hospital eight weeks before the inspection. They said they liked to be visible and often worked as the coordinator due to staffing issues.
- Staff told us the matrons were visible and supportive they told us a matron was usually 'on site' at Dewsbury Monday to Friday. In addition staff said the matrons were always available by telephone. We were told that Heads of Service do visit the ward but it was unclear how frequently this happened.
- Some staff said they wouldn't know who the senior managers of the division were or trust board executives.

Medical care (including older people's care)

- At a focus group we spoke to 23 allied health professionals including physiotherapists, dieticians, radiographers, occupational therapists and staff from the medical physics department. Almost all of these staff told us that they were encouraged, well supervised and had had performance reviews
- Staff talked to us about the planned reconfiguration of services. We were told that there were plans to create an Elderly Assessment Unit at Pinderfields. It was felt that this would improve services for the Elderly population.
- However some staff told us that they felt that a lack of information regarding the reconfiguration of services was impacting on recruitment. This was also reflected by some senior staff within the service.

Culture within the service

- Senior staff told us that there was a desire to improve from the senior management team and that communication and staff training was improving. AHP's told us that they felt 'more listened to' as a group of professionals within the trust.
- All grades of staff we spoke to were aware of the staffing problems across the division. Senior staff on some of the medical wards were using initiatives such as safety guardians and buzzer nurses to help maintain patient's safety. However these initiatives were not consistently used across the medical wards.

Innovation, improvement and sustainability

- The manager of ward 4 was in the process of implementing a 'Hello my name is. . ..' board. Staff photographs and names were being displayed and staff were being encouraged to embrace this initiative.
- A ward manager reported the positive outcomes following the introduction of a music therapist on the ward. We were told that the impact of this initiative had been 'amazing' and how dysphasic service users had responded through singing.
- Staff told us a Tai Chi programme in cardiology rehabilitation had received positive feedback.

Surgery

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

Information about the service

Dewsbury District Hospital provides a range of surgical services, including general surgery, urological and gynaecological surgery, ear, nose and throat (ENT), ophthalmology, day surgery and plastic surgery. There are approximately 71 surgical inpatient beds. There is also a surgical admissions unit and a pre-assessment ward. There are four operating theatres.

We visited all the surgical wards, pre-assessment ward and operating theatres.

We spoke with 10 patients and 13 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified), medical staff (both senior and junior grades) and managers. We observed care and treatment and looked at 11 care records. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Summary of findings

At the last inspection in July 2014 we found that surgery required improvement for being safe, effective, responsive and well-led and was rated as good for caring.

During this inspection we reviewed the progress made against the trust action plan and found that improvements had been made in certain areas however, there remained a number of areas which continued to require improvement for safe, effective, responsive and well-led, caring was rated as good.

Medical and nurse staffing levels remained a challenge; there were gaps in the medical rota which were predicted to rise and shortfalls in registered nurse time. Recruitment was ongoing however not all staff were yet in post. Staff received mandatory training but the number of staff that had completed mandatory training was below the hospital's expected levels.

There continued to be historical management-clinician divides that had not been resolved and tensions remained amongst certain surgical specialties leading to a lack of effective clinical engagement.

Mortality indicators were within expected ranges. Other indicators however, showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours and waiting times, such as the 18-week referral to treatment times and arrangements for the access and flow of patients on to the wards.

Surgery

Patient safety was monitored and incidents were investigated to assist learning and improve care. There were processes in place for infection prevention and control and the management of medicines. Improvements had been made to ensure all anaesthetic equipment in theatres was checked. There were some patient records which were not being consistently completed.

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

Are surgery services safe?

Requires improvement

Safe required improvement. Medical and nurse staffing levels remained a challenge; there were gaps in the medical rota which were predicted to rise and shortfalls in registered nurse time. Recruitment was ongoing but not all staff were yet in post. Staff received mandatory training; however, the number of staff that had completed mandatory training was below the trust's expected levels.

Improvements had been made in the checking of equipment particularly in theatre but there were some gaps in recording checks for resuscitation equipment on the wards. Patient records were completed accurately although some showed care plans and the frequency of patient repositioning for pressure ulcer prevention were not being consistently recorded.

Improvements had been made to ensure that the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were embedded in theatres and briefings before and after surgery took place. Patient safety was monitored and incidents were investigated to assist learning and improve care. There were processes in place for infection prevention and control and for the management of medicines

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

Incidents

- Staff on the wards said they reported incidents using the trust incident reporting systems and were able to tell us that the key themes from incidents related to slips, trips and falls and medicine omissions. Feedback for learning and improvement was provided at ward meetings, governance newsletters and safety briefings.
- The NHS Staff Survey 2014 showed that there had been improvements about the effectiveness of the incident reporting procedures. In particular the trust scored above average in relation to how well informed staff felt about errors and incidents and the feedback they received to reported errors.

- There was evidence of trust wide learning for example minutes of surgery ward meetings showed learning from a Methotrexate incident had been shared to ensure the drug was managed as a controlled drug and prescribed separately and that pharmacy was informed of patients who were receiving the drug**.**
- There were no never events reported for surgery at Dewsbury Hospital. For the period April 2014 to May 2015 there were 25 serious incidents reported for the division of surgery. The majority of these related to pressure ulcers, slips, trips and falls, delayed diagnosis.
- Data for November 2014 to February 2015 showed there were 340 incidents reported for surgery at Dewsbury Hospital. The majority of these were graded as low or no harm and near miss. Actions included improvements in documentation, communication and training and adherence to policy and guidelines.
- Mortality and morbidity meetings were in place in all relevant specialities. All relevant staff participated in mortality case note reviews with joint surgical and anaesthetic reviews and reflective practice. Specialties also discussed cases at the governance half-day meeting. Minutes for April 2015 for general surgery showed that learning included elderly patients to be carefully selected for invasive investigations, optimization of clinical condition and co-morbidities to achieve better outcomes and improved involvement of the teams for very sick and unwell patients.
- Staff were aware of the Duty of Candour Regulations. There was e-learning and written paperwork for staff to follow. The trust performance report showed there were no breaches against the Duty of Candour Regulations.

Safety thermometer

- The trust used the nationally recognised NHS safety thermometer as one of its improvement tools for measuring, monitoring and analysing care. Performance was measured against four possible harms: falls, pressure ulcers, venous thromboembolism (VTE) and catheter-associated urinary tract infections.
- We saw that the safety thermometer was displayed in clinical areas, together with details of 'harm-free days', which indicated how long it had been since a particular type of incident had occurred in that area.
- Data for June 2015 showed 96% of patients in general surgery had received harm free care.
- Data showed between 96% and 100% of VTE assessments had been completed by surgical wards on the Dewsbury site which was better than the trust target of 95%.

Cleanliness, infection control and hygiene

- Infection control audits were completed each month that monitored compliance with key trust policies such as hand hygiene, 'bare below the elbow' catheter and cannula insertion and on-going care. Most areas within surgery demonstrated good compliance in these areas. For example, the elective orthopaedic ward showed compliance with 'bare below the elbows was 100%, environment 100% hand hygiene 92%.
- There was no Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia infections reported for April and May 2015. There had been two cases of Clostridium difficile (C.difficile) for the same period against a trust target of two.
- Data for April and May 2015 showed that 97.6% of acute admissions were screened for MRSA against a trust target of 100%.
- The unit participated in ongoing surgical site infection audits run by Public Health England. The last published results for October to December 2014 showed there were no surgical site infections relating to knee replacements at Dewsbury.

Environment and equipment

- Improvements had been made to ensure all anaesthetic equipment in theatres was checked. Records showed that resuscitation equipment in most clinical areas was recorded each day however on some wards we found there were still gaps in recording. For example, on ward 14 four checks on resuscitation equipment had been missed.
- There was a lack of storage space on ward 14. Patients waiting for a bed prior to surgery had their belongings stored in the ward office. The ward was being re-designed as a dedicated elective unit; this was to meet the new service model which included the separation of elective and non-elective surgery with centralisation of elective work at Dewsbury.

Medicines

- Take home medicines could be prescribed and dispensed from the ward which meant patients were not delayed during their discharge.

- At the last inspection we found that fridge temperatures for storing medicines were not being consistently checked in theatres. During this inspection records showed that fridge temperatures had been monitored and recorded. On the wards we visited medicines were stored safely and at the correct temperature and were recorded correctly.
- Controlled drugs (CD) were stored safely. Audits were carried out by the wards and pharmacy. Monthly audits for the elective orthopaedic ward showed the management of CD's was appropriate.

Records

- There were some inconsistencies in completing documentation. For example, in four records pressure care and falls assessments had not been reassessed following the patients admission. In three records skin checks and the frequency of repositioning patients at risk of pressure ulcers were not recorded. In one record the assessment completed on admission identified the patient as a high risk of pressure ulcers however the care plan had not been started until four days following admission.

Safeguarding

- Data for June 2015 showed that 100% of staff in the divison of surgery had completed Safeguarding Adults training level 1 and 74% for level 2. Data for safeguarding children training showed 100% of staff had completed level 1, 85% level 2 and 100% level 3 against year end trust targets of 95% for Level 1 and 85% for Levels 2 and 3.

Mandatory training

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

Assessing and responding to patient risk

- The trust had implemented portable hand held electronic devises to capture real time clinical data. This provided analysis, reporting and diagnosis of the acutely ill patient by improving the daily clinical processes of observation-taking, early warning scores and appropriate escalation. Staff were positive about the system and said that it alerted clinicians to the location of the 'at risk' patients, allowing them to prioritise workload.
- The trust followed the National Institute for Health and Care Excellence (NICE) guidance to identify deteriorating patients.
- At the last inspection we found that the WHO surgical safety checklist was not being consistently used by staff. We found that improvements had been made in this area. An observational and documentation audit carried out in March 2015 showed the majority of elements of the checklist had achieved 100% compliance with further action identified to improve team brief attendance and documentation.
- In response to a cluster of incidents changes had been made to the perioperative pathway, swab, sharp and instrument policy and review of the swab count chart. This included introducing a flowchart for each theatre to provide the main points when performing the counts and whiteboard charts to use with the perioperative pathway. This was in line with the Association of Perioperative Practice guidance when conducting a swab, sharp and instrument count.
- The observational swab audit for June 2015 identified a few areas for improvement including swab count pause for 'all activity to stop' (89% compliant) and for the theatre team to 'allow time for pause' and 'do not interrupt' (88% complaint). The documentation audit showed 80% of swab counts were correctly recorded.

Nursing staffing

- For the month of June 2015 there was an increase in registered nurse vacancies in the division of surgery by 7.25 whole time equivalents (WTE) to 33.03 WTE. The vacancy position for health care assistants had reduced slightly from 15.07 to 13.66 WTE. At Dewsbury surgical nursing vacancies were 15%. This was an increase and recruitment was continuing. Six registered nurses were due to commence employment by August 2015.
- The trust used the Safer Nursing Care Tool along with NICE guidance to assess required nursing staff levels and 'red flag' events. A red flag is an event that leads to a

patient missing care or sustaining harm (i.e. falls) and indicates that staff were under too much pressure. Once a red flag is raised a prompt and immediate response is required by the nurse in charge.

- During June 2015 there were 172 red flags raised across 9 inpatient wards within the division of surgery. The red flag that raised the most across the division was: shortfall in registered nurse time which was raised 127 times. The highest number of red flags was identified on ward 14 and 15 at Dewsbury Hospital. Staff felt that staffing had become worse in the last 12 months because of increased patient activity and extra beds being open.
- In theatres there was a 4% vacancy rate with a high usage of agency staff (25%) which equated to approximately one agency staff per theatre list.
- The division of surgery discussed staffing and red flag alerts at the monthly quality assurance meetings and matrons reviewed data entry twice a week as a minimum with some doing daily checks.

Surgical staffing

- Consultant medical staff could be accessed 24 hours a day seven days a week. There was also access to the critical care outreach team for deteriorating patients who covered seven days a week (Pinderfields and Dewsbury).
- There were 117 permanent consultants in the division of surgery with 11.7 WTE consultant vacancies at the end of April 2015.
- There were 161 junior doctors on the rota. A report to the Trust Board on medical staffing showed for June 2015 there were 27.5 gaps in the rota and a 19% vacancy rate. This was predicted to increase to 31 gaps in August, 19.5% vacancy rate.
- Recruitment showed that three trust doctors had been appointed to cover general surgery, urology, plastics and orthopaedics with one post remaining to be filled.
- There were 102 locums working in the division of surgery.
- Staff told us that a locum doctor had been based on the surgical wards during periods of high patient activity to review medical patients outlying on surgical wards, however this post had been removed and staff said it was difficult to obtain reviews for medical patients particularly at weekends or bank holidays.

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. The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).There were theatres staffed for emergencies but not all specialties had equitable access across the Dewsbury and Pinderfields sites. These issues were raised at the inspection in July 2014 and remained unresolved between certain surgical specialities. It was not clear what plans were in place to accommodate the additional emergency workloads that would be transferred from Dewsbury Hospital to Pinderfields to ensure NCEPOD recommendations were met.

Mortality indicators were within expected ranges. Other patient outcome measures were the same as, or better than the England average with the exception of patient reported outcome measures for hip replacements which were worse than the England average.

Since the last inspection improvements had been made to reduce the backlog of un-typed clinic letters however, there remained delays in sending discharge letters to GP's within 24 hours and this area was not meeting trust targets (25% against a trust target of 90%).

Evidence-based care and treatment

- At the last inspection there were concerns raised by some doctors about compliance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD); that there was not a dedicated general surgery list. We were informed at the time by the trust that funding was being agreed to provide a general surgery only CEPOD list. The minutes of the general surgery business meeting on 15 April 2015 stated that the current CEPOD lists were being looked at with the proposal that a Friday CEPOD list was to commence by end of April 2015, however this was not possible at this time as a business case was needed. It was therefore unclear what action had been taken to resolve the issue.
- We discussed in detail the process for dealing with emergency cases to ensure compliance with NCEPOD

classification with the senior management team. The data they presented showed that there had been a modest increase of post 8pm operations (approximately 5-10%) over the last 12 months from June 2014. We were told that within the next few months, the Dewsbury surgeons would be operating on their emergency patients at Wakefield and if the National Emergency Laparotomy Audit data was an accurate reflection of the total comparative workloads, this would mean an extra 30% of patients would need to be accommodated on the Pinderfields site. This clearly would have a major impact on the out of hour's service and it was not clear how the division would accomplish this without a dedicated general surgery operating theatre.

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 contributed to all national surgical audits for which it was eligible. National audit data for bowel and lung cancer showed outcomes were within expected ranges. The trust performed better than the England average; for example, being seen by a clinical nurse specialist, reporting of the CT scan and discussion of treatment by a MDT.
- The National Laparotomy Audit 2014 for Dewsbury Hospital showed that 11 of the indicators were not available for example the availability of a fully staffed operating theatre to emergency general surgery patients 24/7. However, the trust said that a theatre list was available during working hours daily and out of hours an acute theatre was staffed which was open and available to general surgery.
- The trust participation rate and outcomes for the Patient Reported Outcomes (PROMS) measures were the same as, or better than the England average in all categories except hip replacement which were worse.
- The average length of stay as at March 2015 reported on the integrated performance report for the Division of Surgery showed that the trust targets had been achieved for non-elective cases and were slightly worse for elective cases (2.97% against a trust target of 2.61%).
- The integrated performance report for the Division of Surgery showed that unplanned readmission rates within 30 days of being discharged for April 2014 to March 2015 was better than the trust targets (elective 3.1% against 3.5% and acute 10% against 12.6%)

Competent staff

- The trust had a target for the division to achieve 85% compliance for appraisal by the end of the year. Records for April and May 2015 showed that 79% staff in surgery had received an appraisal. Data for the last 12 months to March 2015 showed that 66% of non-medical staff had received an appraisal which was below the year end trust target.

Multidisciplinary working

- Since the last inspection there had been improvements in the backlog of un-typed clinical letters to ensure clinical information was available for example to a patient's GP. At the end of March 2015 there were 80 letters requiring dictation which were over the five day target compared to 196 in February 2015. The number of days waiting for the oldest dictation was 9 days in May 2015.
- There remained delays in sending discharge letters to GP's within 24 hours. Performance data for April to May 2015 showed 25% of letters had been sent, which was below the target of 90%.
- Staff said there were good working relationships with consultants, between specialities and with allied health care professionals such as physiotherapy and occupational therapy. 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.

Access to Information

- Staff told us that since the introduction (some time ago) of a system for the electronic scanning of hand written medical records, it had been difficult to access medical records and searching the system was difficult. Consultants may have difficulty accessing medical records prior to undertaking operative procedures. Where consultants knew the patient this risk was mitigated, however, for consultants undertaking waiting list initiative work (RTT clearance), they may have no prior knowledge of the patient and had to resort to re-clerking of the patient prior to surgery.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Action had been taken to improve staff awareness and training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS). Training figures showed 93% of staff had completed level 1, 50% level 2, and 56% level 3 against trust targets of 95% for Level 1 and 85% for Levels 2 and 3.

Are surgery services caring?

Good

Surgical services were caring. The NHS Friends and Family Test showed the majority of patients would recommend the service. Patients spoke positively about their treatment by nursing and medical staff and the standard of care they had received. Some patients said the wards were noisy at night from hospital staff.

Patients were treated by staff with dignity and respect and most were involved in their care and treatment. There were processes in place to ensure patients received emotional support where required.

Compassionate care

- The NHS Friends and Family Test inpatient data for Dewsbury Hospital showed that 96% of patients admitted for general surgery and 100% of patients admitted to orthopaedics would recommend the services to their family and friends.
- Most patients we spoke with were happy with the quality of care they had received. Patients said there were good response times from staff to call bells. Some patients said staff needed reminding to put tables and drinks in reach after providing care and that it was sometimes noisy at night from hospital staff.
- We observed positive, kind and caring interactions on the wards between staff and patients. Staff treated patients with dignity and respect.
- Wards were organised, including single-sex accommodation, to promote privacy and dignity. There were no mixed-sex accommodation breaches in surgery between April 2014 and April 2015.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt they understood their care options and were given enough information about their condition. However, one patient said there was a lack of information and communication about the surgery and post-operative care which had resulted in a readmission for further surgery.
- The NHS Inpatient Survey 2014 showed the trust was about the same as other trusts for providing information and explanations about the operation, procedure and how the operation had gone in a way which patients could understand.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure they had adequate support on discharge.

Emotional support

- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.
- Patients were able to access counselling services, psychologists and the mental health team when required.

Are surgery services responsive?

Requires improvement

Staff were responsive to people's individual needs; however there remained concerns over waiting times, such as the 18-week referral to treatment times and the arrangements for access and flow of patients on to the wards. Some surgeons expressed concerns that the centralised theatre booking system compromised the professional relationship between consultant and patient and therefore limited the ability for surgeons to have pre-operative discussions with anaesthetists, since they may not know which patients had been scheduled for surgery on a given date.

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

care as a result of complaints and concerns. The main themes from complaints related to clinical treatment, cancelled appointments, communication and waiting times.

Service planning and delivery to meet the needs of local people

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

Access and flow

- There continued to be issues in achieving the national targets for referral to treatment times (RTT) in five out of seven specialties in surgery. Data from the division of surgery performance report showed that 75.6% of the admitted pathways completed in May 2015 were completed within 18 weeks against the 90% target. At the end of June 2015 there was one incomplete RTT pathway waiting over 52 weeks in plastic surgery against a trust target of zero. The division had recovery plans in place to improve RTT targets. Performance was reviewed weekly with individual specialties and corporately at an executive level. Additional funding had been agreed for extra clinic lists as well as increased theatre capacity.
- The trust reported 72 last minute planned operations cancelled for non-clinical reasons between April and June 2015**.** All patients who had operations cancelled were admitted within 28 days at Dewsbury Hospital.
- Staff on wards 14 and 15 said due to bed pressures medical patients continued to be cared for on surgical wards which was impacting on the access and flow of elective surgical cases and patient discharges. For example, on ward 15 there were six extra capacity beds for surgery however medical outliers were frequently occupying these beds. Staff said if beds were full elective patients had to wait in the day room until a bed became available. On the day of our inspection there were three medical patients in the extra capacity beds.
- Improvements had been made since the last inspection to ensure beds on the elective orthopaedic ward were protected. This meant hospital-acquired infection rates could be reduced by avoiding admissions and transfers from within/outside the hospital preventing disruption to elective patients.
- Some medical staff told us that the centralised booking of operating lists compromised the professional relationship between consultant and patient and therefore limited the ability for surgeons to have pre-operative discussions with anaesthetists, since they may not know which patients had been scheduled for surgery on a given date. It was felt that surgeons had lost control over their operating lists and patients could turn up for surgery 'out of the blue'.

Meeting people's individual needs

- Staff were working through the 'Person Centred Dementia Care in Acute Hospitals' work book which was facilitated by ward sisters. Most staff had completed training in dementia awareness.
- There were well established systems for flagging of patients as having a learning disability to adjust pathways of care and involve the specialist learning disability nurse.
- Patients using colorectal and breast services were allocated a key worker, usually a clinical nurse specialist, who took a role in the coordination and continuity of the patient's care, including information, advice and access to other specialists when required.

Learning from complaints and concerns

- Between April and May 2015, the division of surgery received 109 formal complaints; 93% of these were responded to within agreed timescales. The main themes related to clinical treatment, cancelled appointments, communication and waiting times.
- There were 96 complaints related to surgery at Dewsbury Hospital between January and December 2014. These included aspects of clinical treatment, attitude of staff, communication and waiting times.
- Meetings from governance meetings showed complaints were discussed and action taken to make improvements such as having a nurse escort on ward

rounds to provide advice and support to patients, improved flagging systems for patients with dementia or learning disabilities and systems to ensure appointment letters were correct and sent at the right time to patients.

Are surgery services well-led?

Requires improvement

Well-led required improvement. There continued to be historical management-clinician divides that had not been resolved and tensions remained amongst certain surgical specialties. These teams remained dysfunctional without local consensus and there was a lack of effective clinical engagement, however there was no evidence to suggest individual clinicians were not caring for their patients or that patient care had been compromised.

There was good contact with staff up to matron level who visited the wards each week; however senior team visibility on the site was less frequent.

The division of surgery had an operating plan which set out its objectives for the next two years; this included a model to centralise acute and complex elective surgery on the Pinderfields site, with elective work moving to Dewsbury and Pontefract.

Governance structures were in place. The trust was developing approaches to improve staff engagement although this work was not yet fully implemented across all surgical areas.

Vision and strategy for this service

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

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.
- The divisions integrated performance report was structured around the five Care Quality Commission (CQC) domains, safe, responsive, caring, effective and well-led. The purpose of the monthly report was to identify and assess the division's performance against the key measures of quality, safety and sustainability against national and local targets.
- Performance was reported using a scorecard; indicators were grouped into six domains based on finance and the five domains of quality identified by the CQC and Trust Development Authority. Each indicator was assigned a red, amber or green (RAG) status based on actual and forecast performance against pre-defined thresholds and reviewed on an exception basis where performance below the required standard was identified. If an indicator was rated as red in any given month or amber for two consecutive periods, a recovery plan was requested from the responsible officer for submission to the following board meeting.
- The divisional risk register was reviewed and managed through departmental and speciality meetings and divisional governance meetings. Risks at division level were identified and captured. There was some alignment between the risks on the risk register and what staff said was on their worry list for example staffing levels.

Surgery

Leadership of service

- Nursing staff spoke positively of each other and reported that working relationships were effective and supportive.
- There was good leadership in the anaesthetic department; however in other areas such as colorectal surgery there continued to be historical management–clinician divides that had not been resolved and there was a lack of engagement amongst these surgical specialities, however there was no evidence to suggest individual clinicians were not caring for their patients or that patient care had been compromised.
- Some ward sisters had completed the 'circle of excellence' leadership programme. For example, one member of staff had shadowed the deputy Chief Nurse which they said had been a very positive experience and a good learning opportunity.
- Staff said there was good contact with the matron who visited the wards each week, however senior team visibility on the site was less frequent; the Director of Nursing had visited the wards before the CQC inspection.

Culture within the service

- Ward staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Most 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.
- Some medical staff said that there was poor retention of operating theatre staff due to lack of flexible working arrangements for staff who wished to work on a part time basis or to request flexible working on returning from career breaks or maternity leave. This lack of flexibility resulted in staff taking positions with other sector providers.
- Monthly meetings were held for staff including night staff. Minutes showed the areas discussed included incidents, new policy and guidelines, trust-wide and operational issues and complaints.
- Sickness absence in theatres had improved from 12% 12 months ago to 3.8%
- The division of surgery performance report showed sickness levels between April and May 2015 was 3.82% which was better than the trust target of 4.4%. The sickness level for medical staff over the last six months to April 2015 was 1.43% against a trust target of 4.4%.

Staff engagement

- The National NHS Staff Survey 2014 showed low levels of staff engagement across some of the specialties. The survey asked staff the question of how likely they would be to recommend the trust; the responses were 45% which remained below the national average of 65% although this had improved from 40% in 2013.
- There was a divisional action plan to address the survey results. For example, the use of 'Big Conversations' was starting to become a common approach to improve staff engagement and involvement. For example, theatres were looking at developing services and processes to work differently.
- The introduction of patient safety panels, the patient safety and 'risky business' newsletter had improved communications and shared learning.
- Staff said they had been consulted on the reconfiguration of patient pathways, ward layout and transition to an elective surgery service model.

Critical care

Safe	Requires improvement
Overall	Requires improvement

Information about the service

The critical care service at Dewsbury District Hospital provided six beds in the Intensive Care Unit (ICU) and four beds in the High Dependency Unit (HDU). In addition to this ward 20, provided another area of High Dependency Care for patients who required closer monitoring than could be provided on a general ward, but who did not require acute HDU care. Ward 20 had space for eight beds but only four were open at the time of our inspection.

During this inspection we visited all three areas, we observed the environment and spoke to seven members of staff, including nurses, health care assistants and physiotherapists.

The service was previously rated as good, with safety rated as requires improvement; this was therefore the focus of this visit.

Summary of findings

Overall we rated safety as requires improvement, the main concerns were regarding the staffing vacancies and skills mix resulting in the Core standards for Intensive care Units not always being achievable. In addition, daily checks of emergency equipment were not always completed.

Throughout critical care there was a lack of sufficient space for each bed area, subsequently meeting the Department of Health Guidance on the critical care environment was a challenge.

We found the checks on resuscitation equipment on the HDU were completed with only two gaps in the records; however we saw on the ICU there were several gaps for the previous four months. The assurance that daily checks were being completed was not evident.

Critical care

Are critical care services safe?

Requires improvement

Overall we rated safety as requires improvement, the main concerns were regarding the staffing vacancies and skills mix resulting in the Core standards for Intensive care Units not always being achievable. In addition, daily checks of emergency equipment were not always completed.

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Environment and equipment

- Throughout critical care there was a lack of sufficient space for each bed area, subsequently meeting the Department of Health Guidance on the critical care environment was a challenge. (Health Building Note 04-02 – Critical care units). This was particularly evident on Ward 20 which was a bay with 6 bed spaces and very little space between each bed. Four beds were occupied on the day of our visit and this was a mix of male and female patients. We were informed by the senior sister that there had been no complaints from patients regarding the mix of males and females in the same bay. Separate bathroom and shower facilities were available.
- We observed the resuscitation trolleys in the ICU and HDU, best practice is for these to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). The checks on the HDU were completed with only two gaps in the records; however we saw on the ICU there were several gaps for the previous four months. The assurance that daily checks were being completed was not evident.
- Other equipment was found to be labelled as clean, and kept in the appropriate storage room.

Medicines

- Medications were stored in a designated room, the door to this room was 'propped' open when we arrived on the unit. The room felt very warm and the temperature was seen to be 27.1°c. The recommended room temperature for the storage of medicines is between 15°c and 25°c (Guidelines for the storage of essential medicines – World Health Organisation)
- We found there were records of the fridge temperature checks being recorded daily, for the previous two months of data we saw there were no gaps and temperatures were all recorded within range.

Nursing staffing

- On the day of our visit the senior sister was also acting as the clinical co-ordinator, however we observed they were busy trying to cover the night shift as two staff had phoned in sick. The core standards identify that the clinical coordinator should be supernumerary and should be in place for each shift. This role was not identified on the electronic rostering system, and staffing levels on the unit did not always allow for this role.
- On the day of our visit there were five level 3 patients on ICU, the Core Standards from the Intensive Care Society state the staffing requirement for a level 3 patients is 1:1 care. This was achieved on the day shift with five registered nurses being on duty. However two members of staff had phoned in sick for the night shift, when we asked how a 1:1 ratio would be achieved overnight we were told one shift had been covered by a 'bank' nurse (booked through NHS professionals) taking the number up to four staff, and that one member of staff would care for the two most stable patients, meaning the 1:1 ratio would not be achieved.
- HDU and ward 20 had four patients in each area, the HDU patients were all level 2 requiring a nurse to patient ratio of 1:2, the ward 20 patients were all level 1. There were three registered nurses on duty for the early, late and night shift meaning the appropriate staffing levels were achieved for these patients.
- Staffing vacancies at band five (staff nurse) was 7 whole time equivalent (WTE), however 2.84 posts had been recruited to and there was on-going recruitment to fill the remainder. There was 1 WTE vacancy at band two (healthcare assistant). In addition to this was short and long term sickness and maternity leave.

- The senior sister said agency and NHS professionals were used as well as shifts covered by the unit's own staff working overtime or hours in excess of contract. The senior sister stated 'I don't feel patients are unsafe' however they further commented they had been completing a Datix form (electronic incident reporting system) weekly regarding unsafe staffing, but had reduced this to completing one monthly.
- We saw staffing levels at Dewsbury critical care unit were not identified on the departmental risk register.
- The senior sister said it was difficult to recruit staff with intensive care experience so the greatest concern was over the skills mix of the staff. This was supported by other members of nursing staff we spoke with.
- We were told this was managed locally by ensuring there was always one experienced member of staff in ICU and HDU, and the staff we spoke to said they felt supported. The trust had also made the decision to keep four beds closed on the unit; this had been maintained since our last visit in 2014.

We reviewed information on nurse staffing from the trust board papers and found:

- ICU
  - We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 90.6% for unregistered nurses it was 47.9%. The fill rate for night shifts was 84.7% for registered nurses.
  - In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts the fill rate for registered nurses was 87.6% for unregistered nurses it was 78%. The fill rate for night shifts was 88.1% for registered nurses.
  - In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 77.5% for unregistered nurses it was 52%. The fill rate for night shifts was 74.2% for registered nurses.
- Ward 20
  - We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 for day shifts the fill rate for registered nurses was 81.7% for unregistered nurses it was 79%. The fill rate for night shifts was 75.1% for registered nurses and for unregistered nurses it was 86.7%.
  - In the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 for day shifts the fill rate for registered nurses was 86.5% for unregistered nurses it was 75%. The fill rate for night shifts was 97% for registered nurses and for unregistered nurses it was 100%.
  - In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 for day shifts the fill rate for registered nurses was 82.8% for unregistered nurses it was 73.7%. The fill rate for night shifts was 77% for registered nurses and for unregistered nurses it was 91.2%.

Maternity and gynaecology

Safe	Good
Well-led	Good
Overall	Good

Information about the service

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

Between April 2014 and March 2015 the total number of births at Dewsbury maternity unit was 2183 births.

In July 2014 CQC carried out an announced comprehensive inspection and found the service was good for effectiveness, being responsive and caring. However, improvements were required for safety as the midwife establishment for the trust was below the national recommendation, and audits showed at Dewsbury maternity unit, not all resuscitaires had been checked to ensure they contained the correct and in date equipment. This meant the equipment might not have been available for use in an emergency situation.

Furthermore, improvements were required relating to the well-led domain. Although there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service, there were mixed messages about how open the culture was within the leadership team; staff felt senior managers were not always visible. The overall rating for the service was requires improvement.

This inspection took place on the 23, 24 and 25 June 2015 and was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection. We inspected the antenatal and postnatal ward; including transitional care, and delivery suite. We spoke with two women who used the service; received three CQC patient feedback forms, and spoke with 14 staff, including midwives, doctors, two consultant obstetricians and senior managers. We also observed care and treatment and reviewed the trust's performance data.

Information about the population of Kirklees shows 18.2% of the population belongs to non-white ethnic minorities. The average proportion of Black, Asian and Minority Ethnic (BAME) residents in Kirklees is higher than that of England (14.6%). Of all 362 Local Authorities in England, Kirklees is ranked as the 77th most deprived.

The trust was re-organising their services and the reconfiguration of women's and children's services was due for completion in 2016. Dewsbury District Hospital will become a midwife led unit comprising of six beds with adjacent outpatient facilities.

Maternity and gynaecology

Summary of findings

Are maternity and gynaecology services safe?

Good

Overall at this inspection we rated the service as good. We found the checking of equipment in delivery suite was now taking place. The birth to midwife ratio had increased from 1:33 to 1:31 since our inspection in July 2014 and the specialist midwife roles for example the Teenage pregnancy, and Infant feeding midwives were not included in these figures. Positive feedback was received from women in relation to them receiving one to one care from a midwife during labour and records showed staff used a 'fresh eyes approach' (Fitzpatrick and Holt, 2008) when monitoring foetal wellbeing through the use of cardiotocography (CTG). The medical staff skill mix at the unit was in line with the England average, and the cover on the delivery suite was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance.

Staff told us they were kept up to date with information about what was happening within the trust; senior managers were approachable and they knew who they were.

Are maternity and gynaecology services well-led?

Good

We found the service was good for well-led. The women's service had a strategy and vision for the future of service provision in Wakefield, Dewsbury and Pontefract. A reconfiguration of women's and children's services was due for completion in 2016 and Dewsbury would become a midwife only led unit. Staff told us they felt they were part of a team and all looked after each other. They told us they were kept up to date with information about what was happening within the trust and senior managers were said to be approachable; they knew who they were. Staff said they felt listened to and supported and would recommend the unit.

Vision and strategy for this service

Maternity and gynaecology

- The women's service had a strategy and vision for the future of service provision in Wakefield, Dewsbury and Pontefract. A reconfiguration of women's and children's services was due for completion in 2016. Pinderfields General Hospital would become a consultant led/ midwife led unit, whilst Dewsbury would become a midwife only led unit like Pontefract. The reconfiguration was in progress following previous consultation with commissioners and other interested parties such as families and members of staff.
- One of the consultant obstetricians told us there were close links between Pinderfields and Dewsbury and they felt these links had got better over the last 12 months. They told us the service at Dewsbury was working in transition over the next 12 months; as a level 2 neonatal unit (NNU). This meant they should provide care for women who were 32 weeks gestation and above. Where there were risks identified of transferring women less than 32 weeks, they would liaise with the staff at Pinderfields. Post inspection, the trust have confirmed that Dewsbury is a level 1 neonatal unit.

Leadership of service

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

Culture within the service

- In March 2014 women's services were placed into one directorate. At the previous inspection we could not fully establish how open the culture was within the leadership team, as we had mixed messages of their openness from staff. At this inspection staff reported a culture which was open and transparent; staff told us they could raise concerns and they felt their concerns would be dealt with appropriately, and this included whistleblowing.
- Staff told us they felt listened to and supported. Staff worked well together, they felt they were part of a team and all looked after each other; they said they would recommend the unit.
- Staff told us the HOM was very supportive; we saw a monthly newsletter 'Current News' which was sent to staff, keeping them up to date with what was happening in the trust. For example, the first edition dated 30 April 2015 acknowledged and praised staff on how they were coping through difficult times. It congratulated staff on new appointments and informed them on how the rolling recruitment programme was maintaining the staffing ratio of 1:31. It acknowledged staff having completed training, and how a survey would be completed to ensure they had the opportunity to use their additional skills and interests. It also informed staff about the rotation programme, and how following a questionnaire asking staff where they would prefer to work, everyone would have the opportunity to work in different areas and remain skilled.
- The newsletter also referred to the HOMs accessibility, stated they accessed their emails daily, and were happy to discuss any suggestions anyone had about improving the service.

Services for children and young people

Safe	Good
Responsive	Requires improvement
Overall	Good

Information about the service

The children's service was managed as a single integrated service across the trust's locations at Dewsbury Hospital, Pinderfields Hospital and Pontefract Hospital (outpatient services only). Pinderfields Hospital acted as the children's service central hub, where the majority of services were provided. Pinderfields Hospital provided a range of children's acute services for Wakefield, Pontefract and Dewsbury. Services provided included paediatric medicine, surgery (including general surgery, ophthalmology, ENT, and orthopaedics for children aged six years and over); therapy and neonatal services.

There was a children's assessment unit at Dewsbury Hospital which consisted of eight beds. It was located next to the emergency department, and accepted admissions from the department and from general practitioners. There was also a special care baby unit (SCBU) that accepted eight babies at the level three special care dependency levels.

During our inspection of Dewsbury Hospital we visited the children's assessment unit, and the SCBU. We talked with three medical staff, nine nursing staff, and examined medical and nursing records. We also spoke with five children and parents.

Summary of findings

At our inspection of the service in July 2014 we rated the safety domain as requires improvement. We had found that there was confusion over version control of risk registers. We also found shortages of nursing staff in all the areas we visited.

At our inspection in July 2014 we found that the outpatient services for children at Pinderfields, Dewsbury and Pontefract hospitals, which were managed and run as one service did not provide enough flexibility to allow cover at all times. During our focused follow-up inspection in June 2015 we found that there was effective version control of the risk register. There were also improvements to the levels of nurse staffing in the outpatients department.

We found at the inspection in July 2014 that the hospital did not hold pre-assessment clinics, which meant consent was most commonly recorded on the morning of surgery. At this inspection we found that the trust was in the process of reviewing the provision of pre-assessment clinics and the process of consent. Parents we spoke with told us they were always asked for their consent prior to surgery, and a full explanation was given.

At the inspection in July 2014 we found that the service was not responsive to the needs of children and young people in that they did not have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes.

At this inspection we found that although the service had appointed a consultant one of whose roles was to lead on transition services that significant changes had not been made since the previous inspection.

Services for children and young people

Are services for children and young people safe?

Good

At our inspection of the service in July 2014 we rated the safety domain as requires improvement. We had found that there was confusion over version control of risk registers. We also found shortages of nursing staff in all the areas we visited.

At our inspection in July 2014 we found that the outpatient services for children at Pinderfields, Dewsbury and Pontefract hospitals, which were managed and run as one service did not provide enough flexibility to allow cover at all times. During our focused follow-up inspection in June 2015 we found that there was effective version control of the risk register. There were also improvements to the levels of nurse staffing in the outpatients department.

However, staff we spoke with in the special care baby unit (SCBU) told us that they had no concerns about staffing except when a sick baby was present. The shortages then became apparent when the two registered nurses were checking drugs, leaving the HCA to look after the sick baby. However, they told us they had a good relationship with Pinderfields and were always able to ask for help.

At the inspection in July 2014 we found that the hospital did not hold pre-assessment clinics, which meant consent was most commonly recorded on the morning of surgery. At this inspection we found that the trust was in the process of reviewing the provision of pre-assessment clinics and the process of consent. Parents we spoke with told us they were always asked for their consent prior to surgery, and a full explanation was given.

Incidents

- At our inspection in July 2014 staff provided us with different versions of the service's risk register, which contained contradictory information.
- During our inspection in June 2015 the trust informed us that this had occurred because staff with different levels of access had shown us the versions of the risk register they were able to access. On this occasion the service's mangers were able to show us up-to-date versions of the risk register that contained all appropriate information. We found there was appropriate and effective version control in place.

Nursing staffing

- During our visit in July 2014 we found that the outpatient services for children at Pinderfields, Dewsbury and Pontefract hospitals, which were managed and run as one service did not provide enough flexibility to allow cover at all times.
- During our visit in June 2015 we were told by staff that the situation had improved as an issue regarding long term sickness had now been resolved.
- Senior managers told us that although there had been no substantive increase in staffing levels the service was under consideration as part of the review into the provision of children's services at Dewsbury hospital.
- Staff we spoke with told us that the staffing situation had improved since our last inspection. They told us there was always one registered children's nurse on duty as well as a healthcare assistant (HCA). They told us there had been shortages of staff previously as sickness had not been covered. They said that a person who had been on maternity leave had not been replaced.
- However, they told us staff absences were now always covered except in the case of sudden unplanned sickness. This was the case on the day of our visit as one member of staff was on unplanned sick leave.
- We found that the planned staffing levels for children's services in the hospital were based on the "Panda" staffing acuity tool developed by Great Ormond Street Hospital for Sick Children; http://www.gosh.nhs.uk/about-us/our-corporate-information/publications-and-reports/safe-nurse-staffing-report/gosh-panda-tool.
- The head of children's services told us they were intending to recruit six advanced neonatal nurse practitioners.
- The head of children's services told us there would also be an advanced nurse practitioner covering the paediatric outpatient department.
- The trust was in the process of reconfiguring inpatient services at Dewsbury and Pinderfields Hospitals, which met national guidelines for the centralisation of children's inpatient services.

Services for children and young people

- At the inspection in July 2014 we found that the special care baby unit had on occasion been left short of staffing because staff had been taken from the unit to work on the neonatal unit at Pinderfields hospital.
- During our visit in June 2015 we found that the nurse staffing met British Association of Perinatal Medicine (BAPM) standards. There were two registered children's nurses and one healthcare assistant (HCA) for eight special care cots.
- Staff we spoke with told us that they had no concerns about staffing except when an acutely sick baby was present. The shortages then became apparent when the two registered nurses were checking drugs, leaving the HCA to look after the sick baby. However, they told us they had a good relationship with Pinderfields and were always able to ask for help.

Consent

- At the inspection in July 2014 we found that the hospital did not hold pre-assessment clinics, which meant consent was most commonly recorded on the morning of surgery. This may have meant that the child, and their parent, may not have had sufficient time to weigh up the benefits or risks of surgery.
- During our visit in June 2015 the senior manager for the service told us the trust were reviewing day surgery to see whether pre-assessment clinics were appropriate.
- Parents we spoke with told us they were always asked for their consent prior to surgery, and a full explanation was given.

Are services for children and young people responsive?

Requires improvement

At the inspection in July 2014 we also found that the service was not responsive to the needs of children and young people in that they did not have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes.

At this inspection we found that although the service had appointed a consultant one of whose roles was to lead on transition services that significant changes had not been made since the previous inspection. Therefore we found that the service still required improvement for responsiveness.

Meeting people's individual needs

- At the inspection in July 2014 we also found that the service was not responsive to the needs of children and young people in that they did not have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes.
- At this inspection we found that the service had appointed a consultant, one of whose roles was to lead on transition services. However, they had not been in post long enough to effect any changes.
- We were also told by the trust that the service was in the process of reviewing the need for a senior nurse to support the consultant.
- However, no evidence was provided by the trust of formal arrangements between services within the trust or with other trusts for the transition of young people to adult services.

End of life care

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

Information about the service

End of life care services were provided across Dewsbury District hospital. The specialist palliative care team (SPCT) had a clinical and educational role within the hospital. The team also provided a service to Pinderfields hospital and Queen Elizabeth house intermediate care unit. The service offered by the team was an advisory one, in which patients remained under the care of the referring medical team.

The SPCT also worked closely with the community palliative care team and local hospices. As part of our inspection, we specifically observed end of life care and treatment on two wards and looked at four sets of patient care records, including medical notes, nursing notes and medicine charts. We also visited the bereavement service, multi-faith centre and mortuary. We spoke with 18 staff including ward nurses, the bereavement officer, the mortuary technician, doctors, porters, the SPCT and senior managers. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

Overall, we found that end of life care services at Dewsbury hospital were inadequate for safety. Effectiveness, responsiveness and being well led all required improvement.

End of life care was provided across the hospital and supported by a specialist palliative care team. The team were focused on providing a high quality service for patients and their families; however shortages of staff and a lack of strategic vision were impacting on the service they could deliver. We found both medical and nurse staffing within the specialist palliative care team to be less than satisfactory for the size of the service they were responsible for based on the number of referrals and information from the team indicating some patients were discharged before being seen. The team received 351 referrals from April 2014 to March 2015, an average of 29 per month. We found senior leaders did not have full awareness or understanding of the challenges of the service, they told us the team was adequately staffed.

There were poor infection control practices in the mortuary and concerns regarding the transportation of deceased infants from the wards to the mortuary. We found the corridors outside the viewing room and mortuary was not suitable for bereaved families to walk through.

We were not assured that the procedure for documenting involvement of patients and relatives with

End of life care

do not attempt cardiopulmonary resuscitation (DNACPR) decisions was in line with the mental capacity act or accordance with best practice, nor that trust policy was being followed.

The process for rapid discharge of patients at the end of life was protracted and lengthy. Not all areas had been trained to use or were using the end of life care plan.

We saw evidence good multidisciplinary working between different disciplines. Bereavement staff and the chaplaincy service supported patients and families and were responsive to their needs. End of life care on the wards was provided in a compassionate and dignified way.

Are end of life care services safe?

Inadequate

We observed poor infection control practice at the mortuary in Dewsbury hospital. We found that staff were not always protected from the risk of infection, the environment or equipment was not cleaned effectively. We observed bodily fluid leakages inside the mortuary fridge.

We saw the corridors outside the mortuary and relatives viewing room were lined with yellow industrial waste bins. The walls and floors were scuffed, dirty and looked extremely 'worn' and unmaintained. We found the storage of waste bins and rubbish outside the viewing room could cause bereaved families unnecessary distress. We observed an inappropriate container which was used to transport deceased infants or young children from the ward to mortuary. Deceased patients did not have head blocks or pillows to support their head; this did not follow hospital policy.

We found the procedure for documenting involvement of patients and relatives with 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions was not always in accordance with best practice, or that trust policy was being followed.

We found that both nurse and medical staffing levels in the specialist palliative care team were unsatisfactory, this had been reflected within the trust risk register. There were five whole time equivalent (WTE) nursing vacancies within the team, this meant only two or three nurses were available. We were told several efforts had been made to recruit but had been unsuccessful. The person specification had been changed in February 2015 to allow increased shortlisting to take place. Staff told us there had been an establishment of five consultants, three were leaving or had left already. Information provided by the trust before our inspection indicated there were 2.6 WTE consultants. It was difficult to ascertain if this was after the doctors had left or the actual establishment. One of the two remaining consultants was due to take up another post which would leave one part time consultant. We found this would place a great deal of strain on the ability of the service to meet the needs of

patients. The trust had tried to recruit medical staff but had been unsuccessful. The team told us they were waiting to hear from the trust board whether they could recruit into some of the nursing vacancies.

Incidents

- There had been an incident report in January 2015 where a registered nurse reported there was no controlled drug (CD) cupboard on a ward. The nurse was working with another newly qualified nurse who was not able to give intravenous medication. A patient needed a syringe driver, so the nurse had to leave the ward on "several" occasions during the shift to obtain and check CD's for the patient by going to two other wards. This left two bank health care assistants and the newly qualified nurse on the ward. The site manager was appropriately informed. It was not clear from the risk register what lessons had been learned or what actions had been put in place to manage this.
- The SPCT met on a weekly basis at a multidisciplinary team (MDT) meeting to discuss all incidents and deaths of patients they were involved with. We were shown minutes of these meetings and other governance meetings; they included feedback from clinical incidents in hospital and the community. For example a medication incident after a patient had been discharged from a Leeds hospital with morphine as an anticipatory medication. Their condition deteriorated and they required a syringe driver. The out of hours GP prescribed diamorphine, despite having access to morphine in the home. This resulted in a delay in the patient receiving the medication. These issues were discussed to share learning.
- One member of the SPCT told us the team did not always receive feedback from incidents submitted concerning end of life care involving other specialties. For example, when there had been communication issues at end of life which involved ward staff, the SPCT had not received feedback. The nurse was unable to recall when this had happened.
- Staff we spoke with were all aware of the incident reporting system and able to describe their role in this to us.

Duty of Candour

- A nurse from the SPCT described to us a situation where duty of candour would be used if something had gone wrong.
- The duty of candour ensures providers are open and transparent with people who use services in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Cleanliness, infection control and hygiene

- We had concerns regarding poor infection control practice (IPC) at the mortuary in Dewsbury hospital. We found that staff were not always protected from the risk of infection. We observed staff to be wearing their own clothes, which were partially protected by standard aprons. Their footwear and lower garments were not protected from spillages.
- At the CQC July 2014 inspection infection control practices had been identified as an area for improvement. During the 2015 inspection we saw the doors of the fridges were scratched and dented which would not allow for effective cleaning. The mortuary trolley was not routinely cleaned after each use; we were told it was cleaned on a daily basis Monday to Friday, as was the one concealment trolley.
- We found there was no evidence the trolleys were cleaned on a daily basis at a weekend or on bank holidays. The trusts end of life care policy stated 'the porter must always decontaminate the trolley after each use before returning the trolley to the hospital".
- We observed leakage from a deceased person inside a fridge who was not in a sealed bag. There were two other deceased patients stored below them. There was a risk of leaking fluids dropping onto deceased patients below. We did not ask if ward staff had been requested to come and clean the deceased patient and transfer them into a sealed bag.
- The concealment trolley had a cover made from non-wipe clean material which could easily become contaminated. It was not clear how often this was changed, or if there was a replacement cover to use.
- We were told the wellington boots provided were used when cleaning. This was inappropriate, the boots were provided as part of personal protective equipment (PPE).
- We were told deceased patients sometimes arrive in sealed body bags without cards to indicate the reason

why. We saw this had happened twice a month on average. In this event, the mortuary technician would ring the ward to ascertain any infection concerns. It was not clear if incident reports were completed when this happens as we were not shown or told of any such reports.
- There were eye wash facilities in the mortuary in case of eye contamination and a covered trolley with linen and other items. Gloves and aprons were available from wall dispensers.

Environment and equipment

- We found the corridors outside the mortuary and relatives viewing room were lined with yellow industrial waste bins. The walls and floors were scuffed, dirty and looked extremely 'worn' and unmaintained. This would be the route relatives and loved ones walked down to the viewing room. We found the storage of waste bins and rubbish outside the viewing room potentially could cause them unnecessary distress.
- Fridge temperatures were recorded on a daily basis Monday to Friday in the mortuary, but not on a weekend or bank holiday. We were told the fridges were alarmed in the event of a power failure and someone from the estates department would respond if the alarms were activated.
- The viewing room environment was very basic and small. There were no chairs in the viewing area; these were in a room to the side. There were no tissues or other facilities for relatives apart from a toilet which was situated near the seating area.
- The viewing room contained an adult trolley and also a wicker style basket for viewing deceased infants. The wicker basket was stored behind the door and had a see through red plastic bag over the top. It was not clear if the wicker basket was removed from behind the door when relatives came to view deceased adult patients.
- We observed a blue 'pharmacy' type crate on wheels in the main storage room. We were told this was used to transport deceased infants or young children from the ward to mortuary. This was not an appropriate means to transport these patients and this was raised with senior trust managers; we were told it was to be taken out of use with immediate effect.
- Deceased bariatric patients were transferred to the mortuary on a suitable bed with a sheet over them. The concealment trolley for other patients had a triangular frame which was covered with material made from a counterpane.
- We observed a deceased patient being brought into the mortuary. Their head was not supported on a pillow on the concealment trolley. The trolley base was made of metal. We saw the process of transporting the deceased might mean skin damage could occur.
- We did not observe any head blocks in use on the mortuary storage trolleys as indicated in the trust policy 'Policy for receipt of bodies into the Dewsbury body store'. (Head blocks are commonly used in order to prevent any stomach contents moving to the patient's mouth). The trust policy indicates head blocks should be used.
- We observed porters using a 'pat' slide to transfer a deceased patient onto the mortuary trolley. During the observation the staff seemed unfamiliar with how to use the equipment. Mortuary staff told us deceased patients were always transferred using this method.
- The trust policy indicated two staff members should complete moving and handling of deceased patients "at all times, including subsequent moving of the deceased". However during our inspection we observed one person transferring the deceased patient into the fridge area after the porters had left. We also found only one person worked in the Dewsbury mortuary each day.
- There were no sharps bins in the mortuary. This meant if a cannula had not been removed prior to the deceased patient transferring to the mortuary; a nurse would have to carry the cannula or other devise back to the ward with them.
- There were three separate fridges for infants or young children. These had clear plastic 'cots' in them instead of a flat trolley base.
- Two nurses on ward 4 told us there were no suitable facilities for breaking bad news on their ward. This had been acknowledged by their manager and there were plans to have identified areas for this in the future.
- There were three bariatric fridges and an 'overflow' storage area in a separate area of the mortuary.
- We were shown a property cupboard in the bereavement office where patients' possessions were securely stored until families collected them.

Medicines

End of life care

- The SPCT gave advice on anticipatory medication to ward doctors and nurses. We saw a flowchart to be used as guidance which had been incorporated into the end of life care plan. The aim of anticipatory prescribing is to ensure in the last hours or days of life there was no delay in responding to a patient's symptoms.
- There had been an audit of syringe driver utilisation and the use of anticipatory medication in 2013. This had been recently repeated and 98% of patients receiving end of life care received anticipatory medications.
- A nurse from the SPCT told us only one team member was a nurse prescriber; another nurse specialist studying for this would be able to prescribe after September 2015. In the meantime this put pressure on the one nurse and did not ensure a fully responsive approach to patient need.
- We did not ask if there was access to an independent prescriber's forum or regularly audit of practice in line with the trust's non-medical prescribing policy.

Records

- There were both paper and electronic records (known as 'i-lab') kept in the mortuary. We observed duplication of effort in the way information was recorded. There were no checklists to ensure accurate procedures were followed.
- The mortuary technician had their own colour code system which they used on the cards outside fridges to identify when certain actions had been taken, for example, ID checked by the doctor, or green cremation form completed by doctor; It was not clear if this code was shared with other technicians, standard checklists were not in use.
- The bereavement officer maintained a stand-alone electronic record of every patient death. They had designed the spreadsheet themselves and could provide information readily if it were needed.
- Four nurses at Dewsbury told us the end of life care planwas easy to use and had a useful section for relatives to complete.

Mandatory training

- Two of the SPCT told us they had completed some mandatory training in their own time as there had not been enough time to do this during paid working hours.
- There was variability in compliance with mandatory training for the SPCT, 76% had attended fire safety; 82 % attended infection prevention and control; Information Governance had 70% compliance; Mental Capacity Act level one had 88% compliance; there had been 100% compliance with level one safeguarding children and adults, moving and handling and health and safety.
- Other training completed by the SPCT had variable compliance, for example consent training had been done by 80% of the team; 77% of the team had done medicines management; 62% had completed patient safety training; 69 % had completed resuscitation training.

Assessing and responding to patient risk

- Two nurses at Dewsbury hospital described how they could respond to patients increasing needs by use of the end of life care plan. They told us it helped them to provide the right level of care when patients deteriorated.

Nursing staffing

- We found that nurse staffing levels in the SPCT were unsatisfactory; this had been reflected within the risk register. The risk register indicated there were five whole time equivalent (WTE) vacancies within the SPCT. We were told several efforts had been made to recruit but had been unsuccessful. The person specification had been changed in February 2015 to allow increased shortlisting to take place.
- The SPCT told us they were established for 9.8 WTE nurses, however, when we inspected the service there were three clinical nurse specialist (CNS) staff members, one was a band 7 and two others were band 6. One of those was in a seconded role as end of life care facilitator. This had been made into a permanent role. The current team leader and end if life care facilitator had been seconded from the community.
- The team covered a bed base of 694 patients between Pinderfields and Dewsbury hospital. Community services were delivered by Kirkwood hospice staff.
- The SPCT nurse triage referrals themselves. We were told there are days when there were two nurses for two hospitals and this could affect patient flow if they needed to be seen by a member of the team.
- A member of the SPCT told us they sometimes are unable to see all the patients referred to them due to poor staffing. They were unable to confirm how often or when this had happened. Referrals could be passed to community colleagues who respond after patients have left hospital.

End of life care

- The manager of the team was on secondment, one of the CNS's was acting up into that role in addition to her own substantive post.
- Two of the CNS's told us they used to work seven days a week for some time in order to meet the needs of the service but this was unsustainable.
- We were told a business case had been submitted for a further substantive post, but there was no news from the trust board whether this would be successful at the time of our inspection.

Medical staffing

- We found that medical staff levels and skill mix were unsatisfactory. The clinical director (one of the consultants) told us there had previously been five consultants, and three were leaving or had left already. The other consultant was due to take up a post at a hospice, which would leave one consultant, who was contracted to provide four hours clinical service a week. We found this would place a great deal of strain on the ability of the service to meet the needs of patients. The Trust had advertised for permanent medical staff but had been unsuccessful in recruitment.
- Information provided by the trust before our inspection stated there were 2.6 WTE consultants, when we inspected we were told it was less than this, the second consultant was based at a hospice and was available for two clinical sessions a week for both Dewsbury and Pinderfields. The specialist registrar was soon to go on extended leave. There was some hospital cover provided by GP's on a temporary basis. Information provided by the trust after our inspection indicated the whole time equivalent for consultants had been reduced from 2.6 to 0.6 due to the lack of available consultants for the consultant post until January 2016. We were told the 1 whole time equivalent registrar post was also reduced from 1 WTE to 0.5 WTE.
- We were shown minutes from the trusts Palliative Care Joint Operational Meeting which indicated a replacement consultant post was not expected to be filled before January 2016 due to recruitment difficulties.
- Out of hours cover was provided by consultants from 5pm to 9 am on weekdays and 9am to 9 am weekends and bank holidays via an on call rota. The consultants covering the rota are based around the region.
- Consultants were available 24 hours a day to give specialist palliative care advice by telephone to out of hours' GPs, hospital doctors, senior community and hospital nurses, and are the designated consultant on call for Wakefield Hospice, Overgate Hospice, Kirkwood Hospice and the Prince of Wales Hospice in Pontefract.
- The clinical director told us they covered approximately one weekend out of six. However we were shown the rota which shows the trust consultant covered two weekends in a row in October 2015; this meant they would have worked 14 days in a row on that occasion. After our inspection the trust confirmed the rota had been amended.

Other staffing

- It was not clear if the lone worker policy was adhered to in the mortuary. We were told only one person was based in the mortuary all day Monday to Friday. It was not clear at the time if their breaks were covered or what support they received working in the mortuary environment. We were told mortuary technicians rotated between Pinderfields and Dewsbury mortuary's on a weekly basis. After our inspection, senior managers told us staff worked short shifts which did not require breaks. They also told us support was available from Pinderfields mortuary or the clinical site manager.
- Mortuary technicians covered 24 hours on an on-call basis, but it was not clear at the time how this fitted in with the manager on call rota for mortuary services. After our inspection senior managers told us the out of hours policy includes information on the role of the site manager.

Major incident awareness and training

- We were shown a mortuary business continuity and action plan for use in the event of a major incident. The document indicated procedures to be followed in such an occurrence. The document was not dated so it was unclear if this was up to date.
- We were also shown a 'back up' pathology systems document which detailed arrangements for care of the deceased if storage systems failed.

Are end of life care services effective?

Requires improvement

There was an end of life care plan which focused on the 'Five Priorities of Care'. We noted that not all areas were

using the care plan. Trust board papers from December 2014 indicated the end of life care plan was to be implemented in all ward areas by June 2015. This had not had not yet been completed by the time of our inspection.

There was an up to date do not attempt cardiopulmonary resuscitation (DNACPR) policy. A trust wide audit of October 2014 there had been a marginal improvement in communication of DNACPR orders with regards to the numbers of wards correctly identifying patients with a DNACPR form; this had risen from 78% in 2013 to 79% in 2014. Correct filing of DNACPR forms had improved from 64% in 2013 to 77% in 2014.

The 2014 audit indicated only 50% of patients who lacked capacity had received either a capacity assessment or had dementia screening; however this was an improvement from 2103 when only 13% of those patients had received a capacity assessment. The percentage of patients with a DNACPR correctly identified on the nurse handover sheet was 20%, against a target of 80%. We found there was less than effective communication with and explanation of decisions about CPR to the patient's family when patients did not have capacity for that specific decision.

Consultants were available overnight and on a weekend.

The number of patients referred to the SPCT who died in hospital was less than the England average, but there was no data available to indicate if preferred place of care was achieved upon discharge from hospital.

When asked in a trust survey, most bereaved relatives (87%) said they had felt included in the care of their family member.

The end of life care planused at Dewsbury demonstrated the team had referred to national standards to ensure patients were appropriately assessed and supported. The SPCT are members of the Yorkshire end of life and palliative care regional group, this is a forum for sharing good practice amongst hospital and community teams. The service was involved in a number of both national and local audits. The results were mixed, although some had been used to improve services to patients.

Evidence-based care and treatment

- The end of life care plan used at Dewsbury demonstrated the team had referred to National Institute for health and Clinical Excellence (NICE) guidelines and the Gold Standards Framework (GSF) for end of life care to ensure patients were appropriately assessed and supported with their end of life needs.
- The SPCT participated in GSF meetings with local GP's to support quality care and prevent unnecessary hospital admission.
- The 'AMBER' care bundle (Assessment, Management, Best practice, Engagement, Recovery uncertain) had been used at the trust since 2013. This was an approach used in hospitals when medical staff and nurses were uncertain whether a patient may recover and were concerned that they may only have a few months left to live. Use of the 'bundle' encouraged staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the patient deteriorate and die.
- The SPCT were members of the Yorkshire end of life and palliative care regional group; this was a forum for sharing good practice amongst hospital and community teams.
- The service was involved in national and local audits which included the national care of the dying audit, the bereaved carers' audit, and the end of life care plan audit. Some audits were due to commence later in 2015 so results were not available. Other local audits in the programme included the palliative day support and therapy patient survey, management of opioids for pain in palliative care patients, and management of metastatic spinal cord compression
- The clinical effectiveness of the SPCT audit had taken place in June 2014; the results were published in August 2014 after the previous CQC inspection. Results showed 92% of patients felt they had been referred at the right time, 98% had met a team member, 100% of patients said they had enough time to talk and felt their dignity was respected.and received clear explanations. Feedback about the overall service showed 67 % thought the service they received was excellent, 25% said it was good and 8% thought it was satisfactory.
- There were a number of actions to be taken as a result of this audit; they included the rollout of the individualised end of life care plan (which was still in progress when we inspected), the development and implementation of an end of life care education strategy, (this had also commenced), and the

development of a business case for substantive post for end of life care facilitator. (There had been a seconded post, made permanent at the time of our inspection). The SPCT patient survey was to be repeated in 2016.

- As a result of the survey, and following the withdrawal of the Liverpool care pathway, a new end of life care plan had been introduced at the hospital and focused on the 'Five Priorities of Care'. These priorities were based on guidance from the Leadership Alliance for the Care of Dying People (LACDP
- There had been an audit to determine the effectiveness of the end of life care plan. 48 care records had been used in the audit. Results showed compliance with the priorities ranged between 64.5% and 95.8%. The lowest compliance rate was for respect for the need of families and meeting those needs as far as possible.
- We saw areas of good practice in the audit were noted as; initial assessment before commencement of the end of life care plan, discussions and involvement of family in decision, and the prescribing of anticipatory medications.
- Areas for improvement were noted as: patient diary completion, daily medical review, completion of 'care after death' section on the care plan, completion of 'spiritual and emotional needs' sections of the care plan; and communication with other agencies.
- Recommendations from the audit were to continue to implement the care plan to all areas in the trust, continue with education of the five priorities of care, to encourage families to use the diary page, and the encouragement of daily medical reviews.
- Trust board papers from December 2014 indicated the end of life care plan was to be implemented in all ward areas by June 2015. This had not had not yet been completed by the time of our inspection in late June. We did not ask why this had been delayed.
- The SPCT told us the care plan had been 'rolled out' on the wards, except wards 14 and 15, the acute assessment unit and short stay wards at Dewsbury. Staff on ward four told us they hadn't received training so weren't using the care plan either. It was not clear what care plan these areas were using for patients at the end of life.
- The bereavement officer carried out audits of medical staff complying with accurate and timely completion of death certificates. We observed doctors completing the audit forms which were kept next to the death certificate log; this enabled compliance with the audit. Results were not yet completed so were not available to us.
- The bereavement officer told us she was responsible for collecting the end of life care pathways from medical notes and passing these on to the SPCT for audit purposes.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

- There was an up to date (DNACPR) policy. A trust wide audit report of October 2014 indicated there had been a marginal improvement in communication of DNACPR orders with regards to the numbers of wards correctly identifying patients with a DNACPR form; this had risen from 78% in 2013 to 79% in 2014. Correct filing of DNACPR forms had improved from 64% in 2013 to 77% in 2014.
- The 2014 audit indicated only 50% of patients who lacked capacity had received either a capacity assessment or had dementia screening; however this was an improvement from 2013 when only 13% of those patients had received a capacity assessment. The percentage of patients with a DNACPR correctly identified on the nurse handover sheet was 20%, against a target of 80%. We found there was less than effective communication with and explanation of decisions about CPR to the patient's family when patients did not have capacity for that specific decision.
- Other concerns highlighted in the audit were a variety of terminology related to DNACPR (such as DNR, DNAR, 'Resus- yes', 'Resus –no'). Some ward handover sheets had 'DNACPR' printed next to every patients name with a tick or cross next to it.
- Further concerns were documented 'medical' reasons for DNACPR such as "bed bound", "multiple medical problems", "frailty", "nursing home resident", "additional medical problems" and "poor physiological rescue".
- We saw a number of recommendations had been made as a result of the audit. For example we saw recommendations for the need to standardise the terminology of "DNACPR". Other recommendations were for doctors to clearly document DNACPR decision including evidence of discussion with the patient and/or relative and for doctors to consider the 'medical reasons' and ensure they were reasonable and justifiable.

End of life care

- A further 'spot check' DNACPR audit was carried out in January 2015. This indicated the percentage of patients with a DNACPR correctly identified on the handover sheet to be 20%, against a target of 80%. The percentage of patients with their resuscitation status considered at consultant review within 12 hours of admission to be 36%, against a target of 50 %.
- There were improvements of the percentage of forms where there was a valid reason for decision not to discuss withpatient documented on the form; this was 94% against a target of 70%. As a result of the findings, the trust had decided to carry out monthly spot checks from February 2015. There had been an audit in March 2015, but we were told the full results and action plan were not available to us as they had not been collated.
- We reviewed four 'do not attempt cardiopulmonary resuscitation' (DNACPR) records at Dewsbury; all were filed appropriately at the front of medical records; one record had illegible reasons for DNACPR, the patient was deemed to not have capacity to be involved in that specific decision, but a discussion had not been had with the family. Records stated a capacity assessment had taken place but this could not be seen in the records.
- The second DNACPR form stated the patient had dementia and that a capacity assessment was needed on 8th June. On 25th June SPCT had documented "there is a question of capacity to make the decision re end of life care". It was not clear if this meant the patient had variable capacity. We did not see the capacity assessment in the records.
- The third DNACPR form indicated the patient had a progressive type of dementia, the records stated "discussed DNR" with the patient's spouse, but no further detail was written. We could not find any evidence in the patient notes to indicate this had taken place. The Resuscitation Council guidelines (2015) recommend "effective communication with and explanation of decisions about CPR to the patient's family, friends, other carers or other representatives, or clear documentation of reasons why that was impossible or inappropriate." The trust DNACPR policy stated "…this is good practice and is required by the Mental Capacity Act 2005".
- The fourth DNACPR form indicated the patient had severe heart failure. The records appropriately showed this had been explained to the family and patient regarding DNACPR status.

Pain relief

- Symptom management guidance had been produced by the SPCT and was available on the trust intranet and on posters which had been supplied to the wards. The guidance covered key symptoms in the last days of life and key prescribing points, such as pain relief medicines and advice on dosage as needed or over a 24 hour time range.

Equipment

- Ward nurses told us they used the standard McKinley syringe drivers. These were maintained by the medical physics department and kept in an equipment 'library'.
- One nurse on ward 4 told us there were only standard easy chairs for relatives to use when they were staying overnight with patients who were dying. We did not ask senior staff if other equipment was to be obtained for this purpose.

Patient outcomes

- The trust participated in a national audit of bereaved relatives from January to March 2014, 29 relatives took part. Results showed 87% of relatives felt involved in care of the patient. This compared to a national average of 76%. Results for families being involved in discussions about intravenous fluids were marginally better than the national average at 40% compared to 39% nationally. There was less than average emotional support offered to relatives at 40% compared to the national average of 63%. When asked if the patient died in the right place, 60% felt they had done, compared to a national average of 72%. Nationally, 76% of relatives felt supported, this compared to 67% locally.
- The comments from the survey indicated many patients and families received good care and felt well supported, although the audit commented too that these comments had not been consistent and other families reported great difficulties. The report stated the trust was aiming to achieve 100% in future audits.
- On average 27.6% of the patients referred to the SPCT died in hospital. This compared to an England average of 36.8% for 2013/ 2014. On average 72.3% were discharged to other places of care.
- There was no data available to indicate if preferred place of care was achieved upon discharge from hospital, this had been audited, but we were told the results had not been collated.

End of life care

Competent staff

- The mortuary technician we spoke with was able to clearly explain their role and responsibilities. They told us they had attended mandatory training but were unable to recall what this was. They had not attended other specific training which might support them in their role such as advanced communication with bereaved relatives.
- We asked mortuary staff if they received clinical supervision; they did not think they did as they did not recognise the description of this.
- We were told 70% of the SPCT had received an appraisal in the preceding year.
- Nurses on ward 2 told us they had received training from the SPCT to use the end of life care planand found the care pathway easier to use as a result of the training
- The end of life care facilitator told us 60 staff trust wide had been trained on use of the five priorities for care in January and February 2015. We were shown records which indicated a total of 158 staff were trained on the five priorities of care and the end of life care plan from February to the end of April 2015. The trust subsequently reported that 598 staff were trained in the five priorities of care and use of the new end of life care plan between January 2015 and June 2015.
- The SPCT showed us a programme from March to November 2015 for end of life care training. We were told the training was often cancelled as nurses found it difficult to be released form the wards for education sessions.
- One of the SPCT told us there was “a deficit in the knowledge of general nurses on the wards” in relation to end of life care, despite the training.
- There were no individual ward nurses who acted as the ‘link’ nurse for end of life care. We were told there used to be a programme for link workers; however shortfalls in staffing meant this had to be cancelled. There was hope this would be restarted in September 2015.
- The SPCT deliver training sessions for new doctors during their induction to the trust induction.
- Some staff in the SPCT told us they had to undertake study in their own time as they could not obtain study leave, even though the training was relevant to their role

Multidisciplinary working

- We observed good MDT working between the bereavement officer and medical staff, and also between the mortuary technician and medical staff.
- The porters and mortuary technician appeared to have a good collaborative relationship.
- The chaplaincy team told us they worked together with the SPCT in development of the end of life care plan.
- The SPCT hold a weekly MDT meeting, to discuss all new referrals and patient diagnosis; they develop management plans for patients and confer on areas of complaint or concern about the service.
- We saw evidence of good internal and external MDT working in patient records, for example collective working between medical staff, nurses, community teams and hospice staff.
- Staff told us the trust was about to begin some work on updating an electronic palliative care coordinated system (EPaCCS) which had been implemented from April 2014. All end of life patients seen in the hospital have their information placedon EPaCCS if they give their consent. An EPaCCS system allows for speedy communication and joint working between hospital and community teams.

The SPCT nurses told us they were not staffed adequately to be able to participate in ward rounds in order to share good practice. Senior managers told us the SPCT participated in some multidisciplinary team meetings and met frequently with other specialist nurses. The Royal College of Physicians (RCP 2013) recommends joint working between palliative care staff and other services.

Seven-day services

- Consultants were available from 5pm to 9 am weekdays and 9am to 9 am weekends and bank holidays via an on call rota. The consultants covering the rota were based around the region.
- If a death certificate was needed out of hours, for example for a Muslim burial, the on –call manager arranged for the doctor to complete the death certificate in an appropriate timescale.
- The SPCT told us on a weekend in the event of ward nurses and doctors needing support to care for end of life patients, they had to manage with telephone support only. Ward staff who spoke with us told us this was satisfactory as they had not experienced any other kind of weekend cover.

End of life care

- Two members of the SPCT told us the chief nurse would be involved in future decisions over 7 day working, as it felt unsustainable to continue with the current way of working.
- One of the SPCT was writing a masters dissertation about seven day working; they told us the chief nurse would use the evidence from the dissertation when considering the future of the service.

Access to information

- We were shown booklets which were given to bereaved relatives when they collected the death certificate from the hospital. The booklets had useful information about what procedures to follow and gave some bereavement advice. We were also shown an information leaflet for 'relatives and carers of the dying patient'.
- When the SPCT visited a patient they give them a green card with contact details on, this card also had an out of hours number for GP's in case the patient and family need this service after discharge.
- None of the leaflets or cards we saw was available in languages other than English. A member of the SPCT told us interpreters would be used if someone did not speak English.
- The SPCT is in the process of updating EPaCCS. (This is a patient register which can be accessed by primary care services in the community such as GP's, district nurses, and hospice at home teams, and also the hospital and community SPCT team. Use of EPaCCS minimised the likelihood of patients at the end of life being asked sensitive questions more than once.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a DNACPR policy in place; the policy included instructions on communication decisions when a patient lacked capacity.
- We reviewed four 'do not attempt cardiopulmonary resuscitation' (DNACPR) records at Dewsbury; the first one indicated the patient was deemed to not have capacity, no discussion had taken place with the family, Records stated a capacity assessment had taken place but this could not be seen in the records when we checked.
- The second set of records stated the patient had dementia and that a capacity assessment was needed on 8th June. On 25th June SPCT had documented "there was a question of capacity to make the decision re end of life care". It was not clear if this meant the patient had variable capacity. We did not see the capacity assessment in the records.
- The third set of records indicated the patient had a progressive type of dementia, the records stated "discussed DNR" with the patient's spouse, but no further detail was written. When we looked in the patient records there was evidence a conversation had taken place.
- A DNACPR audit in 2014 indicated only 50% of patients who lacked capacity had received either a capacity assessment or had dementia screening. Two of the SPCT told us they had worked closely with the safeguarding team to include mental capacity issues into the end of life care plan. They felt this had supported some improvement.

Are end of life care services responsive?

Requires improvement

A member of the SPCT told us they sometimes are unable to see all the patients referred to them due to poor staffing. Referrals could be passed to community colleagues who responded after patients had left hospital.

Relatives were actively discouraged from viewing deceased patients outside of working hours; however, if relatives had travelled as significant distance the technician on call was available to attend . We found this did not take the needs of bereaved families fully into account.

The process for discharging 'Fast Track' patients (those who may be entering a terminal phase of illness with only a short prognosis) was very lengthy. This meant patients with an increased length of stay, could acquire infections, and in the case of those with a very short prognosis, die in hospital against their wishes. This had been highlighted at the trust Palliative Care Joint Operational Meeting in May 2015.

There had been 351 referrals from Dewsbury hospital to the SPCT from April 2014 to March 2015; this was an average of 29 per month. 68% of referrals were in relation to cancer diagnosis, 20% for non-cancer, and 11% for 'not known'. (Some patients had more than one primary diagnosis and this affected the results which totalled 99%).

End of life care

The SPCT had worked with other professionals to develop clinical pathways for patients at the end of life with specific conditions such as heart failure and patients with chronic obstructive pulmonary disease (COPD).

The multi faith area had good provision for Islamic patients, staff and visitors. There were specific ablution areas and designated prayer areas for men and women. There was also a chapel area with Christian symbols. A quiet room was available for anyone to use.

The mortuary technician was very respectful of deceased patients. The bereavement officer told us they had arranged for funeral services for deceased babies whose parents could not cope with a funeral. Chaplaincy volunteers at Dewsbury carried out pastoral care such as listening to and supporting patients and their families in end of life situations.

Service planning and delivery to meet the needs of local people

- We were told an audit of preferred place of care (PPC) at end of life had been carried out but the results were not yet available
- There had been 351 referrals from Dewsbury hospital to the SPCT from April 2014 to March 2015; this was an average of 29 per month. 68% of referrals were in relation to cancer diagnosis, 20% for non-cancer, and 11% for 'not known'. (Some patients had more than one primary diagnosis and this affected the results which totalled 99%).
- We found 20% of the referrals received by the SPCT from April 2014 to March 2015 were for patients with a non-cancer diagnosis. The SPCT had worked with other professionals to develop clinical pathways for patients at the end of life with specific conditions such as heart failure and patients with chronic obstructive pulmonary disease (COPD).
- The trust has a policy 'Dealing with Deaths of Muslim Patients and procedures to be followed' which supported families of Islamic faith to obtain death certificates quickly. The policy referred to procedures to be followed if families wished to take the deceased patient out of England for burial.

Meeting people's individual needs

- The multi faith area had good provision for Islamic patients, staff and visitors. There were specific ablution areas and designated prayer areas for men and women. There was also a chapel area with Christian symbols. A quiet room was available for anyone to use.
- The trusts end of life care policy states "viewing … in the place of rest is by appointment only during office hours." It also states "Relatives should be discouraged from viewing out of working hours. Out of working hours if the relatives have travelled any significant distance the technician on call will attend." We found this did not take the needs of bereaved families into account.
- One nurse on ward 4 told us the process for discharging fast track patients could be improved, we were told of two situations where patients chose to die at home but this was not achieved, they died in hospital. We were told the delays were due to the discharge process used for Fast Track patients; (these included a doctor signing a Fast Track tool, a lengthy assessment of needs document completed by a ward nurse, the sending of assessments to the Clinical Commissioning Group (CCG), the wait for a decision before further planning could take place.). The process could take several days by which time patients significantly deteriorated.
- The SPCT told us there were issues with side room space for end of life patients, the rooms were too small for families to comfortably stay with patients.
- We saw the mortuary technician was very respectful of deceased patients.
- The bereavement officer told us they had arranged for funeral services for deceased infants whose parents could not cope with a funeral. The hospital chaplain carried out the services. The bereavement officer also had attended funerals of patients with no family or friends.
- We were told of examples where interpreter service had been used to liaise with family overseas regarding deceased patient's possessions.
- We were told of an end of life patient who was going to die in hospital being able to have their dog brought in to visit them.
- Nurses on wards 2 and 4 at Dewsbury told us the SPCT were responsive and supportive.
- There was a bereavement service based at Kirkwood hospice, which relatives of patients who died in hospital could access, bereaved families could refer themselves to this service

End of life care

- There were 'comfort bags' which contained toiletries and other items; staff gave the bags to family and carers to use if they were staying overnight.
- A member of the chaplaincy team told us they use the relative's page in the end of life care plan to respond to specific concerns when they are supporting families.
- There were four chaplaincy volunteers at Dewsbury; the chaplain told us the volunteers carry out a lot of pastoral care such as listening to and supporting patients and their families in end of life situations.

Access and flow

- A member of the SPCT told us they received referrals via an electronic 'ICE' system, or over the telephone. They told us wards did not always communicate the urgency of a referral so a team member would go to see the patient in order to establish the speed of response needed.
- The SPCT nurse triaged referrals themselves. We were told there were days when there are two nurses for two hospitals and this could impact on patient flow if they need to be seen by a member of the team. We asked for evidence of this but were told this was anecdotal.
- In April and May 2015, 96% of patients referred to the SPCT were seen within two working days of referral.
- There had been 351 referrals from Dewsbury hospital to the SPCT from April 2014 to March 2015; this was an average of 29 patients per month. 68% of referrals were in relation to cancer diagnosis, 20% for non-cancer, and 11% for 'not known. (Some patients had more than one primary diagnosis and this affected the results which total 99%).
- Two members of the SPCT told us the process for discharging 'Fast Track' patients (those who may be entering a terminal phase of illness with only a short prognosis) at end of life involved the Fast Track tool being completed by a senior doctor; the ward nurse, then completed a lengthy nursing needs assessment which had to be faxed to the single point of access. It is then sent to the Clinical Commissioning Group (CCG) so a funding decision can be made. We found no one takes responsibility for Fast Track discharges. This meant patients had an increased length of stay, could acquire infections, and in the case of those with a very short prognosis, die in hospital against their wishes.
- This lengthy process impacted on how quickly patients could be discharged from hospital and was highlighted at the Mid Yorkshire Palliative Care Joint Operational Meeting in May 2015. It was felt that a change in procedure to the hospital Integrated care team being involved had affected length of stay. It was noted also ward nurses did not have time to complete fast track assessments. There were plans to consider other models of neighbouring trusts.
- We were told there was a community palliative care at home team for end of life patients who lived in Wakefield, but patients discharged to Dewsbury areas did not receive this service, and this could affect the safety and speed of discharge from hospital. Community palliative care services were provided by an external partner; this meant Mid Yorkshire trust was limited in how they might influence this.
- In March 2015, a total of 958 trust-wide delays were reported to NHS England, it was not possible to extract specific data for end of life patients at Dewsbury hospital, but in that month four patients were awaiting assessment and 24 were waiting for public funding. Only 93 delays were attributable to social services, all other delays were NHS related.
- An electronic palliative care coordination system (EPaCCS) had been implemented from April 2014. All end of life patients seen in the hospital have their information placed on EPaCCS if they give their consent. EPaCCS can be used to help prevent re-admission to hospital by sharing use of the system with the Emergency Department. This meant a patient could be assessed and treated then returned to the care of community services.

Learning from complaints and concerns

- We were shown clinical governance notes from December 2014 where it was highlighted that shared learning from complaints was discussed at this meeting. The complaints we read about had occurred in the community, yet were discussed in hospital as a way to improve the whole service.
- The bereavement officer told us if a family brought up concerns or complaints when they came to their office, they asked the ward manager to come and listen to the family and try to resolve issues at an early stage. The ward manager would be expected to take issues back to the ward team for learning.
- Senior managers told us there were two ways of learning from complaints; firstly by the use of action plans, and monthly governance meetings which looked at themes of complaints.

End of life care

- The second method they told us of was at local level, when ward teams met to look at nursing issues. Senior managers told us in the past families have been asked to come in to speak to staff about their complaint. This was considered to be a "powerful tool" to help staff learn lessons. We did not establish under what circumstances this kind of learning would be used.
- One of the SPCT described any complaint or concerns at the end of someone life was 'heart wrenching' as they tried hard to do their best for patients.

Are end of life care services well-led?

Requires improvement

Overall we found senior leaders did not have full awareness or understanding of the challenges of the service. We found leaders could better engage with and understand the value of staff raising concerns and participating in decisions about the service.

There was no up to date end of life strategy for the trust; we were told the SPCT had a two year work programme instead. We found the lack of strategy or vision for the service contributed to the reactive rather than proactive approach to end of life care. We found a lack of support and opportunity for development for mortuary staff we spoke with.

One of the SPCT was acting up in the absence of a manager and was supporting colleagues while still carrying out their own role. There was no evidence of succession planning, and little opportunity for development due to staffing resources being restricted. The SPCT provided peer support to each other in the absence of a team leader or senior manager and worked hard to achieve the best for patients. The clinical director of the service was also the consultant and was based at Wakefield hospice. There were many demands on the person in post who was not available on a full time basis

We were told routine items necessary for the SPCT role had to be purchased from a trust fund. Following the inspection the trust told us non- stock orders had been paid for by the trust for example the Palliative Care Formulary. Staff told us they were "fire fighting" and not recognised for the work they did. There was a lack of opportunity to learn from other areas of good practice as they were a reactive service.

The SPCT were fully aware of their roles and responsibilities regarding effective risk management and governance processes were in place. All patients receiving end of life care were discussed at a weekly clinical review meeting. The SPCT collected and analysed their activity data and reported this to the trust and the National Council for Palliative Care. There was engagement with bereaved families through participation in the national audit. Not all trusts participate in this due to the emotive nature of such as survey. We found the SPCT wanted to measure itself against national standards and improve services so they engaged with families as a way of achieving this.

Vision and strategy for this service

- Palliative care services belonged to the directorate of 'specialist medicine'. The chief nurse was the designated executive board member for end of life care. There was also a non-executive director responsible for end of life care.
- There was no up to date end of life strategy for the trust; we were told the SPCT had a two year work programme which included their focus up to 2016.
- We found the lack of strategy or vision for the service contributed to the reactive rather than proactive approach to end of life care.

Governance, risk management and quality measurement

- We were shown notes from a clinical governance review meeting from December 2014 where it was queried whether seven day working ought to be on the risk register. It also noted staff were working overtime to mitigate staffing shortages.
- We were shown notes from a clinical governance review of December 2014. This highlighted the SPCT were struggling to provide support to ward staff due to staffing levels within their team. Nurse staffing was included on the trust risk register, there had been a plan to recruit but this had been unsuccessful. We found this was a continued risk to the team.
- There was no evidence of succession planning, and little opportunity for development due to staffing resources being so restricted. This remained a risk to the sustainability of the team in both the short and longer term.

End of life care

- The SPCT were fully aware of their roles and responsibilities regarding effective risk management and governance processes were in place.
- All patients receiving end of life care were discussed at a weekly clinical review meeting.
- The SPCT collected and analysed their activity data and reported this to the trust and the National Council for Palliative Care**.**
- The SPCT was involved in both hospital and community MDTs at which all deaths and concerns were discussed. Morbidity and mortality was discussed on alternate months; the other month was a business meeting.

Leadership of service

- We were concerned during our inspection as there were occasions when managers answered questions we had directed to junior staff.
- There was a lack of opportunity for development and no additional training available for mortuary technicians.
- One of the SPCT was acting up in the absence of a manager and was supporting colleagues while still carrying out their own role.
- The SPCT provide peer support to each other in the absence of a team leader or senior manager. We were told a medical matron and a head of nursing were senior leaders of the SPCT, but they did not provide visible day to day contact.
- Some of the SPCT we spoke with had clinical supervision outside of the trust in their own time. This indicated to us that there was a lack of senior support available in discussing issues with senior managers.
- Nurses were recruited to the SPCT as a band 6. We were told over time they become more skilled and competent and leave to obtain a higher band in another trust.
- The clinical director is the remaining SPCT consultant and is based at Wakefield hospice. There were many demands on the person in post who was not available on a full time basis.
- Overall we found senior leaders did not have full awareness or understanding of the challenges of the service.
- The bereavement officer told us they were well supported by their manager and felt valued. They had received annual appraisals and had objectives.

Culture within the service

- We were told routine items necessary for the SPCT role had to be purchased from a trust fund; this included the palliative care formulary, a guide for prescribing medicine in palliative care.
- The SPCT told us they "could do so much more if the trust invested in them" and there was better staffing.
- We found the culture of end of life care had improved on the wards. The majority of end of life care was delivered by general staff and we found they were frustrated about offering care which could be of a higher standard if staffing levels were improved.
- Two of the SPCT told us they were "fire fighting" and the trust did not recognise them as a speciality service, they did not feel they were recognised for the work they did. We found there was a lack of opportunity to learn from other areas of good practice as they were a reactive rather than proactive service.
- We found a small number of staff members we spoke with were reluctant to divulge information to us
- We found the SPCT to be a close team who focused on providing high quality care for patients at the end of life. They had pulled together in difficult circumstances.

Public engagement

- There was engagement with bereaved families through participation in the national audit. Not all trusts participate in this due to the emotive nature of such as survey. We found the SPCT wanted to measure itself against national standards and improve services so they engaged with families as a way of achieving this.

Staff engagement

- Staff told us senior leaders had not engaged with the SPCT in order that their views could be reflected for planning and shaping the service in the future. We were told the SPCT had not been consulted about how the service might be improved.
- Following the inspection the trust told us end of life care facilitator had been involved in the work programme of 2015- 2017 which had looked at service improvements.

End of life care

- Staff told us leaders could better understand the value of staff raising concerns and participating in decisions about the palliative care service.

Innovation, improvement and sustainability

- The SPCT were participating in a pilot for a new way of how palliative care will be funded. This has been agreed with the CCG and would mean any domiciliary visits carried out by the consultants will be paid for per visit rather than by block contract.
- We were shown a DVD which the SPCT had made in order to support training of staff to break 'bad news'. The roles of patients had been played by volunteer actors.

Outpatients and diagnostic imaging

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

Information about the service

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

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

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

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

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

Summary of findings

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

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

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

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

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

Are outpatient and diagnostic imaging services safe?

Good

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

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

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

Incidents

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

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

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

Environment and equipment

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

Medicine management

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

Mandatory training

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

Assessing and responding to patient risk

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

Staffing

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

Diagnostic staffing

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Overall we rated the service as good for being effective. The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. We found that policies based on NICE and Royal College guidelines were available to staff and accessible on the trust intranet site.

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

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

Evidence-based care and treatment

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

Patient outcomes

- Within the diagnostics and radiology service there was a designated radiologist for research. We found they produced an annual report on audit and research activities within the department.

Outpatients and diagnostic imaging

- We found the department had an annual audit plan with estimated start and end dates. For example we saw there was an audit planned to start in September 2015 of Magnetic resonance imaging (MRI) scans in Transient ischaemic attacks (TIA's) and was due to end in March 2016. This was to audit against NICE guidance.
- Within outpatients local audits had been undertaken one audit looked at the timeliness of the clinicians arriving for clinic and the impact of this. Results showed generally clinicians arrived on time however it did identify that some clinicians consistently arrived late and these were escalated to the relevant management team.

Competent staff

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

Seven-day services

- Within outpatients staff told us there were evening and clinics on Saturdays and Sundays for patients to access. The Trust has confirmed that this is for some specialties to provide additional capacity. For example the colorectal service was running outpatient clinics on a Saturday and Sunday.
- The lung cancer clinic was a Monday- Friday 9am-5pm service but staff told us all patients were advised on how to get support out of hours.
- The radiology service provided a range of services, some covering 24 hours, seven days a week, and some within normal and or extended working hours Monday to Friday. For example
  - GP Walk in chest x-ray service was open Monday-Friday 08.30 - 20.00 hrs.
  - All other GP plain film x-rays were booked appointments on Monday – Friday 08.30 - 20.00 hrs.
  - Outpatient plain x-ray service was run in conjunction with the outpatient clinics. The department was notified of any additional evening or weekend clinics so that additional staffing could be planned and organised.
  - At Dewsbury the CT and MRI scanning department was run by volunteer staff into the evening but there was no formal rota to support scanning in the evening this was done out of hours by on-call staff.
  - Ward plain x-ray 24/7 7 days a week (during the night patients sleep is not disturbed if possible. Mainly urgent requested carried out overnight).
- The outcomes of the working practices change review which as due to be completed on 1 November 2015 meant that all hours 24/7 will be part of staff contracted core hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

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

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

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

Service planning and delivery to meet the needs of local people

- Managers in the call centre told us the centre was responsible for outpatient bookings for medicine and surgery, answering calls from patients, partial booking and follow-up appointments for patients who had been on a ward in the hospitals.
- We found the trust had a policy for the management of the follow up waiting list (January 2015) the purpose of this policy was to minimise the clinical risk to patients who were waiting for a follow up appointment. The policy also outlined the process staff should follow to manage patients within the backlog of appointments.
- The next phase of the overall outpatient improvement plan was to look at services who managed their outpatient bookings outside of the call centre. Each service was to be reviewed separately so that decisions about outpatient bookings would be based specifically around the needs of that speciality.
- Staff told us within the outpatient departments processes had been standardised so that this was the same at each hospital site this also made it easier and safer for staff when they rotated between sites.
- Within the outpatient call centre managers and staff told us that since the last inspection in July 2014 staff worked more flexibly to cover peaks in activity
- Staff within outpatients told us the process they had used to address the backlog of outpatient appointments identified at the inspection in July 2014. The process had been split into two parts a clerical validation and a clinical validation which looked at managing risks to patients.
- Staff within the call centre told us the most challenging areas for appointments was Neurology due to having several specialities within this and Ophthalmology where there were capacity issues.
- As part of the inspection one person contacted CQC directly and told us they had difficulties accessing their eye appointment they were supposed to have appointments monthly but had been told by the trust it could be 12 weeks before they would have an appointment. They reported they were worried in case their condition worsened.
- Prior to this inspection Healthwatch and patients raised some concerns about the Cardiology clinic and delays in receiving a follow-up appointment. Staff we spoke to at the inspection told us there were still issues with capacity within cardiology.
- One patient we spoke with on an inpatient ward told us they had been seen in outpatients in April 2015 and was told they would be seen again in six weeks. They told us they had three outpatient appointments cancelled the first appointment was the 2 June at Dewsbury, the second was 16 June at Dewsbury and the third cancelled appointment was 30 June at Pinderfields Hospital. These had all been cancelled by 13 June 2015 the patient told us they then contacted the consultant directly and was seen on 16 June 2015.
- GP patients who had suffered a bony injury in the last 10 days, could use the walk in service and be x-rayed immediately.

Access and flow

Outpatients and diagnostic imaging

- At our inspection in July 2014 we found there was a backlog in overdue outpatient appointments of 9,501. At this inspection the trust provided information on the outpatient backlog we saw in April 2015 the number was 3,716 in June 2015 this number was down to three patients.
- Managers confirmed this and told us that as of 24 June 2015 there were 3 patients in the backlog who were waiting for an appointment.
- Admitted pathways are those that end in an admission to hospital (either inpatient or day case) Between August 2014 and June 2015 for completed admitted pathways analysis of data showed the trust was performing between 76.4%-91.4% against a target of 90%.
- Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required. For completed non-admitted patients the performance in the same time period was between 85.9%-94.3% against a target of 95% for referral to treatment times (RTT) within 18 weeks.
- Incomplete pathways are patients whose RTT clock is still running at the end of the month. For incomplete pathways between August 2014 and June 2015 the trust performance was 90.4%-93% against a target of 92%. From September 2014 the performance has been above the 92% target.
- We reviewed information on the trust's performance for cancer waiting times. We found from October 2014 the trust performance for two week wait from urgent referral was between 97%-99% against a target of 93%.
- We found between November 2014 and June 2015 the trust was generally meeting the 85% performance target for all cancers for the 62 days wait for first treatment from an urgent GP referral with the exception of February 2015 when it was 78.8%.
- A mandatory process had been introduced to support staff to cancel or rearrange clinics where six weeks' notice had not been given. Staff within the call centre told us the clinician had to complete a form to state why the clinic needed to be cancelled. The patient list was then made available to the clinician so they could review and manage the patients care and make alternative arrangements where needed.
- Senior staff within outpatients told us the did not attend (DNA) rate had reduced within the department. The reasons for this had been the service had re-introduced a text and remind service and letters from the call-centre had improved the letters and tried to see patients at hospitals closest to where they lived. The DNA rate was now 9%.
- For June 2015 the call centre was consistently achieving 95% of all calls answered within the three-minute response time.
- If a patient who had been referred by their GP for an x-ray had a suspected fracture on their x-ray, staff took them to A&E where they would be seen immediately. Similarly, if significant pathology was seen on a chest x-ray, the radiographer would show the x-ray to a radiologist. The GP would be telephoned and the patient asked to go to their GP the next day for the results.
- Staff at Dewsbury told us the last time a clinic was cancelled on the day was about two weeks previous and this was due to a mix-up in the co-ordination and booking of appointments and clinics.

Meeting people's individual needs

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

Learning from complaints and concerns

- Staff were able to describe the clear processes they followed for complaints and the timescales to respond to any complaints they received.
- The trust provided information which showed between February to June 2015 outpatient services have received 220 complaints. The themes from these were 43% related to clinical treatment, 27% related to date for appointment/ attendance, 13% related to communication and 7% related to staff attitude.

Outpatients and diagnostic imaging

- Staff within outpatient services told us the number of complaints about outpatient appointments had reduced since the inspection in July 2014 and the backlog of appointments had cleared.
- In diagnostics and radiology managers told us complaints about the service tended to be a small part in a larger complaint regarding the patients care whilst receiving care at the hospital. Senior managers gave an example where a patient had been informed they had a fracture when they didn't.
- Staff told us the last complaint received by the outpatients department at Dewsbury had been in September 2014 and this had been in relation to the attitude of staff.

Are outpatient and diagnostic imaging services well-led?

Good

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

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

Vision of the service

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

Governance, risk management and quality measurement

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

Outpatients and diagnostic imaging

- We found within both outpatients and diagnostics and radiology there were monthly governance meetings where trends from incidents and risks within the division were discussed. For example senior managers told us they had discussed at one of these meetings there had been a slight increase in radiation risks one month no reason for this had been identified and the following month this had decreased. Managers told us this was quite unique and the department were hoping to present about this at UK Radiological Conference next year.
- The diagnostics and radiology department use the Q-Pulse document management system. All governance documents were filed on Q-pulse, including mandatory training, all polices and incidents. The system sends alerts via email either to individuals or across departments when updates were required. For example individual updates for mandatory training.
- Within Q-Pulse under the list of policies and protocols local Rules were available. Staff showed us how they were alerted and how they acknowledged them electronically.
- We saw samples of risk assessments for the x-ray rooms were seen and we found they were comprehensive and completed to a high standard.
- The reporting radiographers (Advanced practitioners) met monthly to discuss discrepancies and any interesting cases. There was a proforma for staff to complete at the time of reporting which was then added to the list for discussion.
- Staff told us the department had raised an issue regarding the effect on the department on windy days. The main corridor becomes like a 'wind tunnel' and impacted on patients who may be waiting in the corridors including unwell ward patients. This has been raised through the risk register and risk assessment. Staff had put forward a solution is to have the doors open and close on a timer mechanism which would give sufficient time for the porters to pass through. Staff raised concern of the length of time it was taking to resolve the issue

Leadership of service

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

Culture of the service

- Staff throughout the service told us they felt the culture within the organisation had changed and one person told us "it is now completely different."

Outpatients and diagnostic imaging

- Staff reported that there was now more open doors, they were made to feel they could ask questions, there were no "stupid" questions and managers always had time for the staff.

Public Engagement

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

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

Outstanding practice and areas for improvement

delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.

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

In addition the trust should:

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- The trust should ensure staff are involved and informed of service changes and re-design.
- The trust should take actions to address the historical management–clinician divides that had not been resolved amongst certain surgical specialities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines and that oxygen is prescribed in line with national guidance. The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment. The trust must ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented. The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients. The trust must ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours. The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis. The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users and to meet their needs.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are met.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients. The trust must ensure where actions are implemented to reduce risks these are monitored and sustained. The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board. The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed. The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.

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

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