The Mid Yorkshire Hospitals NHS Trust

Pinderfields Hospital

Quality Report

Aberford Road
Wakefield
West Yorkshire
WF1 4DG
Tel: 0844 811 8110
Website: www.midyorks.nhs.uk

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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
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.

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

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

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

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

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

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

Summary of findings

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

We saw areas of good practice including:

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

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

Importantly, the trust must:

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

Summary of findings

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

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	There were concerns over interdepartmental learning throughout all the three EDs, sharing of lessons learned from incidents, root cause analysis and Serious incidents did not occur. A number of infection prevention and control concerns were identified e.g. inappropriate placement of alcohol gel, general cleanliness of the environment and equipment and assurance of cleanliness was not provided. Mandatory training rates showed low levels of compliance for both medical and nursing staff The department had a good level of participation in audits of the College of Emergency Medicine (CEM) standards. Patient fractured neck of femur 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 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. 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 70% of occasions. 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.

Summary of findings

Medical care **Requires improvement**

Overall we rated the service as requires improvement. We rated safety as inadequate, effective, caring and well-led as requires improvement and responsive as good. We had serious concerns regarding the registered nurse staffing levels particularly on Gates 20, 41, 42 and 43 at the unannounced inspection which had impacted on the care patients received. We found the assessment and completion of risk assessments in relation to falls were not always completed fully as a result we found patients did not always get the level of care and support they needed. There were gaps in medication administration and oxygen therapy had not been prescribed. On Gate 41 the fridge temperature for 23 out of the 24 days was recorded as exceeding 8 degrees centigrade. 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.

Patients and relatives told us care was good but sometimes staff were too busy to support them. Some patients told us they had to wait unreasonable amounts of time for their call bells to be answered. We observed during our inspection two members of staff speaking with patients in an unkind and disrespectful manner on both occasions we brought this to the attention of senior managers in the trust.

We found the number of medical outliers had reduced on surgical wards since our last inspection in July 2014 and respiratory medical staff were assigned to these patients to ensure they had an appropriate medical review. We found the service had specialist roles to support people's individual

Summary of findings

needs which included respiratory specialist nurse and a learning disability nurse. Gate 43 had been designed as a dementia friendly ward and on Gate 41 the ward was developing a suite of two rooms to care for patients with a learning disability. The rooms would have a pull out bed for relatives, a welcome pack and drinks making facility. They aimed to create a 'home from home' environment for the patient. There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Following the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information which detailed the immediate, short-term and longer term actions they were going to take to make the improvements that were needed. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards. We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward.

Generally staff told us they felt well supported by their line managers and were able to escalate concerns in the knowledge that they would be listened to. Some staff told us there had been frequent changes to their line manager and they would welcome stability.

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 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 the number of emergency admissions following elective and non-elective admissions. There remained concerns over waiting times, such as the 18-week referral to treatment times and arrangements for the access and flow of patients on to the wards and theatres. There were dedicated theatres for emergencies but not all specialties had timely access such as colorectal surgery and it was not clear what plans were in place to accommodate the additional emergency workloads that would be transferred from Dewsbury Hospital.
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, however on some wards we found there were gaps in recording of checks for resuscitation equipment. There were also inconsistencies in completing documentation particularly pressure care assessments. Improvements were required in the layout and facilities on some wards to improve patient experience.

Maternity and gynaecology

Good

Overall at this inspection we rated the service as good. We found in delivery suite, daily checks of essential equipment to ensure it was available in an emergency situation were not taking place. This information was also found at our previous inspection in July 2014. Although steps had been taken to try to address this in 2014 and in the week prior to our inspection, it was too early to show changes had taken 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, Bereavement midwife 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. The medical staff skill mix at the unit was in line with the England average, and the cover on labour ward was 98 hours a week. This was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance that there was 98 hours of consultant presence for a unit with 4000–5000 births.
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

We undertook a focused follow-up inspection in June 2015. This followed an earlier inspection in July 2014 where we found the safe and responsive domains required improvement.
At this inspection we rated safety as good, whilst we rated responsiveness as requires improvement.
At the July 2014 inspection in the safe domain we found that staff did not always receive feedback on incident reports, and there was confusion over version control on risk registers. We also found shortages of nursing staff in all the areas we visited.
At this inspection we found that staff did receive feedback on incident reports, and that there was clear version control on the risk register. There were improvements to the levels of nurse staffing. The service had committed resources to bringing in additional members of staff. Although not all these staff were in place at the time of the inspection the trust were actively recruiting. Within children's services we found that safe staffing levels were maintained by staff working extra hours, and through the use of temporary agency staff. Therefore we found that the service still required improvement for safe.
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 were 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. We also found in July 2014 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 whose role 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 responsive.

End of life care — **Requires improvement**

We found end of life care services at Pinderfields hospital to require 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. There had been 777 referrals to the SPCT from April 2014 to March 2015. This was an average of 65 per month. We found senior leaders did not have full awareness or understanding of the challenges of the service.
The process for rapid discharge of patients at the end of life was protracted and lengthy. We observed examples where discharge had been unnecessarily delayed .Not all ward staff had been trained to use or were using the end of life care plan.
There had been some improvement in documentation around involvement of patients and relatives with ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions. We found a small number of records where the mental capacity act and trust policy had not been followed.

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.

Pinderfields Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Pinderfields Hospital

Pinderfields Hospital is part of the The Mid-Yorkshire NHS Trust. It is situated in Wakefield and serves a population of approximately 355,000 people in the local Wakefield and Pontefract area and 185,000 people in the 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, paediatrics and maternity care. The hospital had approximately 639 beds.

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

We carried out a follow up inspection of the trust between 23-25 June 2015 in response to a previous inspection as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust in July 2014. Following the announced inspection in June 2015 CQC received a number of concerns and on further analysis of other evidence an unannounced focussed inspection took place on the 25 August 2015 on Gates 20, 41, 42 and 43 at Pinderfields Hospital. We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made.

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 Pinderfields Hospital

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

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	N/A	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	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

Urgent and emergency services

Safe	Requires improvement
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 General Hospital (PGH), Dewsbury District Hospital (DDH) and Pontefract General Infirmary (PGI) each site has an emergency department with total attendances in 2014-15 of 216,728, which equated to approximately 18,000 attendances per month.

Attendance data showed that on the Pinderfields site 105,000 patients a year which equated to 250-300 patients per day. A quarter of these attendances were from children, which equated to approximately 1,700 attendances per month, 50-60 patients a day. Attendances for children had risen from 19,645 January to December 2013 to 20,319 under 17 attendances per year January to December 2014.

Of the total number of patients attending the ED, there were 87,775 attendances between July2014 to May 2015 of these 24% (27,984 patients resulted in admission to hospital which is higher than the England average of 21.9%. The emergency department was open 24 hours a day, seven days a week. Paediatric admissions were accepted 24 hours a day.

On the day we visited it was very quiet in the ED department and by 3.30pm only 70 patients had been through the department, in a typical day the ED department would have seen about 100-150 patients by that time in the afternoon. Staff expressed concerns regarding the times the department was busy and they were unable to transfer the patients who require admission to the wards, due to no beds being available; however during our inspection we did not observe this...

The emergency department included a ‘majors’ area where patients with an acute illness or injury were treated, a ‘minors’ treatment area where patients with a minor injury or illness were treated, a dedicated paediatric area, assessment trolley cubicles, a triage room and two see and treat rooms.

During inspection we spoke to 9 patients and 30 members of staff including qualified and unqualified nurses, medical and ambulance staff. We reviewed 10 sets of electronic records and documentation and reviewed information provided by the trust prior to our inspection.

Urgent and emergency services

Summary of findings

There were concerns over interdepartmental learning throughout all the three EDs, sharing of lessons learned from incidents, root cause analysis and serious incidents did not occur.

A number of infection prevention and control concerns were identified e.g. inappropriate placement of alcohol gel, general cleanliness of the environment and equipment and assurance of cleanliness was not provided. Mandatory training rates showed low levels of compliance for both medical and nursing staff

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. 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. 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.

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 70% of occasions.

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 general environment was very well maintained and was currently in the process of refurbishment to increase capacity; the areas provided for relatives were excellent. 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?

Requires improvement

There were concerns over interdepartmental ED learning and sharing of lessons learned from incidents, incidents were shared internally on the hospital site and with Pontefract hospital; however sharing did not occur between Pinderfields to Dewsbury. Medical and nursing staff was not aware of the actual top themes from incident reporting, low levels of pressure ulcer reporting were found, learning from serious incidents and the root cause of incidents was not fully disseminated. Staff reported incidents of patients deteriorating due to the high numbers of patients in the department.

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

Receptionist cover in the main department had been intermittent in the previous months due to receptionist sickness rates.

There were a number of infection prevention and control issues identified. Alcohol gel was hung from the sink, increasing the risks of contamination. High levels of dust were found in the resuscitation department. Solutions used for disinfection were not stored appropriately. Equipment was observed and was found to be unclean; this equipment had been labelled as clean and stored inappropriately.

Paediatric patients were mixed with adults attendances overnight, and had no specific child friendly area to wait or be assessed. Risks occurred in the department when extra capacity areas were opened.

Medicines were not always stored and stock recorded appropriately. Stock was not found to be rotated correctly and sterile stock was found out of date.

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

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

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

Incidents

- Pinderfields ED reported 134 incidents (rated as harm which was moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between February 2015 to May 2015. 319 incidents were reported in total for the three ED's at the trust.
- At Pinderfields the reported incidents showed none were graded as severe, 2 were graded as moderate harm, 25 low and 107 as no harm/ near miss.
- All incidents within the ED were reported through a centralised reporting system. Senior nursing and medical staff reviewed the incidents reported and analysed the data to identify any trends.
- 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.
- Learning from incidents was shared via the sisters meetings, communications book, email system and through circulating memorandums. Medical staff spoke to us about how they cascade lessons learnt from incident down to junior medical staff, and the processes involved if a medical trainee was involved in incidents. Trainee staff spoke to us explaining they recorded any incidents they were involved in, within their personal portfolios. Staff also shared incidents within a staff meeting which was held once every six months on the Pinderfields site.
- Staff told us that they do receive individual feedback if an incident form had been submitted by them. Staff were aware of a recent paediatric incident, and the themes related to that incident had been shared via email.
- The trust made incident data available, we reviewed incident data since February; we identified that the top three incidents were referral from primary care to

secondary care (74 out of 134), abuse of staff via patients (47 out of 134) and pressure ulcers (25 out of 134). Nursing staff we spoke to said the top three incidents were pressure ulcers, falls and violence and aggression. Medical staff thought these were community acquired pressure ulcers.

- The amount of pressure ulcers reported is much lower than the amount recorded in Dewsbury. This is against a similar number of admissions on both sites. This could suggest a low level of reporting or recognition of pressure ulcers on admission. Staff told us there was some reluctance to incident report due to time constraints. Senior nursing staff had an update of incidents via the leads meetings and they were shared on the nursing dashboard. These were 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 Pinderfields.
- Root cause analysis investigations were undertaken in the ED. Staff could explain the process for dissemination of the findings. One RCA reviewed was recorded in September 2014 on the Pinderfields site regarding elevated cardiac blood levels and a failure to review patient in a timely manner, recommendations had been put in place including a memorandum to all long-term junior doctors. On reviewing incident data for Dewsbury a similar issue had arisen on the Dewsbury site in May 2015, together with another incident were a patient had sat in the waiting room for 4 hours without review due to lack of space to review the patient, this patient had elevated cardiac blood results. It was unclear how well lessons learnt were shared between the three departments from the original incident in September 2014.
- No never events were recorded. Never events are serious incidents, which are wholly preventable as guidance and safety recommendations that provide strong systemic protective barriers are available at a national level. The department did not hold specific mortality and morbidity meetings however there was evidence these were discussed as part of the governance meetings.
- Staff spoke to us about specific changes to practice; an example was as a result of a hospital acquired pressure ulcer a pressure ulcer checklist had been developed.
- The department didn't have team meetings, but it recently introduced a safety briefing into the handover where incidents are discussed.
- Staff reported issues about patients who had deteriorated whilst waiting transfer to a tertiary care provider. Incident forms corroborated that on one occasion, observations were not done due to the high workload and another occasion where the severity of the patents condition was not escalated. The senior medical team assured us that on all occasions, even when the department was busy every patient has their observations recorded every hour.
- On reviewing incident data, inappropriate handover to ward staff was noted on four occasions, a root cause analysis investigation demonstrated this had been due to failure to communicate to the ambulance transfer staff or the surgical assessment unit staff. One of the recommendations from this incident was to provide a written document for handover and staff to be taught the importance of verbal handover. This practice was not embedded as four further incidents occurred in the following few months.

Duty of Candour

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

Safety Thermometer

- In the reporting period July 2014 to December 2014 overall in the three EDs, 20 harms had been reported under the safety thermometer reporting system, 4 pressure ulcers, were recorded in October/November

2014, none recorded in the previous 9 months. 12 falls were recorded these peaked in July 2014 and reduced towards the end of the reporting system and 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 was 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 May 2015 a score for patient equipment was noted as 80%.
- We saw cleaning assurance labels were used on trolleys and a handmade laminated sticker recorded the last time trolley was cleaned. When we visited on the 24th June 2015 we saw one label identified that the trolley had last been cleaned on 18.06.15.
- Trolley mattress were checked internally on 5 trolleys and two were found to be damaged and puncture holes were present allowing for staining on the mattress. Three out of seven mattresses labelled as clean were found with staining, sticky residues and debris present on the mattress.
- We also saw on 5 out of the 7 trolleys checked the base of the trolley under the mattress was found to be dirty and had debris present. Mattress inversion, tipping the trolley mattress on its side was used on the Dewsbury site to indicate cleanliness this was not a procedure undertaken on all the three EDs and no mattress were seen inverted on the Pinderfields site.
- Four equipment procedure trolleys had dates of cleaning as 24.06.15, on further inspection 3 of these were visible dirty with staining present. 3 had various square dust caps missing from the top of the trolley legs, which meant they would be difficult to clean. Internally in the drawers of these trolleys equipment for annulation was stored and high levels of dust were present.
- An intravenous (IV) stand was found to be in use and damaged and had been taped up with dressing tape. This would make it difficult to clean. A blood pressure cuff (blue) was found to be contaminated with a brown/ red staining. This was labelled as being cleaned at 7.00am 24.6.15.
- Three commodes were labelled as clean 24.06.15, on further inspection staining was found to the cage of one commode and the casters and wheels of two commodes were dusty and dirty. Slipper pans were labelled as being cleaned; we saw evidence of liners being used.
- Equipment stored in resuscitation was not always labelled as being clean, equipment such as patient warming equipment was stored on the floor, and two pharmacy boxes were stored on the floor full of equipment. Seven IV stands were stored in cubicle one, four had cleaning labels attached and three did not. Two fluid warmers didn't have labels attached as clean equipment.
- 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.
- Adherence to the "bare below elbows" policy was good with all staff observed as being "bare below elbows".
- An environmental checklist was used in the cubicles; this was signed and dated to provide assurance of cleanliness.
- We observed that bottles of alcohol hand rub were hung from the sink in several cubicles this was despite wall mounted alcohol gel dispensers being above the sink. Hanging alcohol gel from the sink increases its chance of contamination from waterborne bacteria. Health Technical Memorandum 04-01:addendum Pseudomonas aeruginosa- advice for augmented care units
- There had been no cases of acquired MRSA or Clostridium difficile within the ED noted in the previous year.
- We observed domestic cleaning schedules being available the ED.
- The NHS carries out audits against set standards to monitor the level of cleanliness, The national specifications for cleanliness in the NHS: a framework for settings and measuring performance outcomes April 2007 at the previous internal audit in May 2015 a score of 94.75% was noted, Emergency department are routinely classified very high risk departments (98% compliance) so a breach of cleanliness standards had occurred.
- The children's ED was inspected and found to be clean and well maintained.

- In a corridor opening we saw a storage racking system was in use, the racking system contained spare liners for commodes and bedpans, a drawer storage system was also present and these drawers stored various items of clinical equipment these were found to be dusty and two blood culture bottles stored in this area were found to be out of date.
- Blood spots were noted on the trays used for IV drugs, these were reported and they were cleaned straight away.
- We noted internal IPC audits had a compliance rate of 44% for aseptic non touch technique the score is a marker of quality of the asepsis used in patient care when carrying out invasive procedures, and highlights poor levels of compliance with asepsis.

Environment and equipment

- The department had a six trolley resuscitation department five for adults and one bay for paediatric admissions. 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.
- Within the resuscitation room, we saw the area around bay 1 was extremely cluttered with spare equipment making it difficult to clean.
- A room was available that was dedicated to treating patients with mental health needs.
- In the main ED department access was available to toilets facilities, two relative's room were available and were decorated and maintained to a good standard, relatives had access to drinks
- Staff told us that capacity in the ED was an issue due to the increased attendance rates. The department was currently undergoing some building works to increase the size of the nurse's station and to make four new cubicles. Due to the building works the store room for ED was in the process of re-configuration an office on the Paediatric side of ED was being used as a store room, for the main ED this room was very cramped but had good storage cupboards with doors and shelf's located in it. Staff told us that this room was not big enough for the needs of the ED department.
- A decontamination room was available for patients who had been in contact with a chemical or biological agent; we saw this room was cluttered and due to the amount of stock and equipment being stored in this room it would be difficult to empty should its use be required. The decontamination room had a shower in it for showering when exposed to chemicals or biological incidents; due to the cluttered nature of the room this shower could not be run which increases microbiological risks from waterborne bacteria, legionella and Pseudomonas Health Technical Memorandum 04-01: addendum Pseudomonas aeruginosa- advice for augmented care units and Legionnaires' disease. The control of legionella bacteria in water systems Approved code of practice and guidance.
- On electronic equipment no electrical testing stickers were present, staff were not aware of the way to check this equipment had been tested the inspection team queried this and saw evidence of testing and recording centrally.
- Staff change female shower area was blocked by boxes and general clutter this shower couldn't be run, which increases the risks of waterborne infection.
- We observed an environmental checklist which was signed daily by the co-ordinator which included check of medicines, general environment and equipment.
- We saw in the paediatric emergency department that a mixture of cots and trolleys were available, seven open curtained cubicles and one cubicle with a door. It was decorated in bright and colourful child friendly designs on the walls. It was well maintained and well equipped with children's toys and play facilities. There was a waiting area in the children's ED which led directly into the department
- A room that was normally used for chairs was being flexed into a two bedded cubicle when required, in this room there is only one wall based oxygen point, staff were not aware of any risks that had occurred from using the rooms flexibly.

Medicines

- There were processes in place for ensuring medications were kept securely. Medication fridges were found to be locked when we checked them. Fridge temperatures were manually recorded and were within expected limits.
- All medicines cupboards were found to be locked. When we looked in the cupboard we found medications were not stored in date order. For example we found dressings with older dates at the bottom of the pile and newer dates at the top.

- Similarly we found IV bags of fluid were stored with bags which were due to expire sooner at the bottom and the bags with longer expiry dates on the top. In the arterial line drawer a bag of sodium chloride IV solution was found out of date December 2013 and in the central line box a preparation used for sink disinfectant was found to be out of date in 2012.
- We saw an open bottle of skin disinfectant solution was found there was no date as to when the bottle was opened. These bottles are classified as single patient use.
- Three bottles of IV solution, were stored in front of the computer hard drive in the resuscitation room, the increased temperature in this area due to the computer would affect the IV solution.
- Controlled drugs were stored according to legal requirements. Controlled drug books were checked were completed with signatures and dates.
- We saw allergies were recorded on patient record cards and within the IT patient administration system.
- Patient Group Directives (PGD's) were written instructions which allowed 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 the PGD's and found them all appropriate we observed them to be fully signed by individual staff.

Records

- The emergency department used an electronic patient record system widely used within the NHS. Nursing and medical documentation in the ED was stored electronic.
- All staff were provided with access to the system and provided with training on how to use the system. Locum staff also had access to the system.
- Staff told us about the information held on the system and that information could be scanned into the system for example observation sheets.
- We reviewed 10 sets of patient records. We found the relevant sections within the notes to be 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 65% to 78% for nursing staff and 76% for medical staff at Pontefract and Pinderfields.

Safeguarding

- The department had systems in place to safeguard vulnerable adults. The 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 79% and 87% for nursing staff and 84% for medical staff for safeguarding level 2 and 3 training at Pinderfields and Pontefract.
- Staff were able to discuss issues around sexual exploitation and female genital mutilation. These issues were contained within the level 3 safeguarding programme. A symbol was present on the computer system for children known to be at risk.
- Staff were aware of the key individuals in the trust for safeguarding advice for the maternity service, children's and adults.

Mandatory training

- One of the must do's in the CQC 2014 report was to ensure that all staff attend and complete mandatory training and role specific training particularly for safeguarding and resuscitation. Information about levels of compliance with statutory and mandatory training was supplied to us by the trust pre the inspection, compliance for medical staff averaged 80%and nursing staff 80.5% Resuscitation training compliance data supplied by the trust was low with 73% nursing staff and 68% medical staff completing training. We discussed compliance with senior staff within the department and they told us compliance was low due to the current staff vacancies within the department. On reviewing incident forms we noted 2 incidents where the resuscitation trolley hadn't been checked and items were missing this could be because staff had not received up to date training and did not recognise the importance of checking the equipment.
- Statutory and mandatory training was delivered by a mixture of face to face and e-learning training sessions. Staff we spoke to told us about new e-learning training programmes they accessed, they also spoke to us about

difficulties they had accessing the system at work as the programmes freeze and crash and so they have now arranged for remote access at home to complete their e-learning.

- Medical staff new into the ED spoke to us about attending a 3 day induction programme containing the training required for mandatory training.
- Staff spoke to us about the allocating and compliance with mandatory training now being easier due to the training being a full day.

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 an initial assessment. Early warning scores (EWS) were used to assess adults. An early warning score is a guide used by staff to quickly determine the degree of illness of a patient. It is based on data derived from four physiological readings blood pressure, heart rate, respiratory rate, body temperature and one observation of level of consciousness.
- Children arriving by ambulance were transferred into the paediatric area or the paediatric resuscitation area. Paediatric early warning scores were used to assess children. Staff told us they used national EWS and nursing staffing used these scores to escalate patients to medical staff for review. Staff were aware of the need to refer patients with a EWS over 6 to the outreach team. Senior medical staff told us that when the department has increased capacity all patients are monitored using EWS criteria and all have observations undertaken every hour.
- Patients arriving on foot initially checked in at the reception area. Those patients who can be seen by a nurse practitioner were allocated by the receptionists via set criteria on the computer.
- The ambulance receptionist was located on the reception desk in the main department. Ambulance staff told us that if they were not present this increased the time of their handover as they have to wait to book the patient in.
- Patients with a minor injury waiting the main waiting area to be seen by a nurse practitioner. In the department they operated a 'see and treat' facility were the patient was seen initially and treated within one consultation.
- We observed the triage of patients. Triage was staffed by senior nurses whilst we were in the department, staff told us it was provided by senior staff in the morning and staff nurses in the afternoon or evening, staff were declared competent before providing triage alone.
- An Initial three bedded assessment area was available where patients admitted directly on foot or via ambulance were assessed prior to attending the minor's stream or the major's stream.
- Waiting times for triage during our inspection for triage were within the recognised timescales of 15 minutes from attendance. Prior to the inspection time to initial assessment (triage) times were not supplied by the trust as a new dashboard was been finalised and these weren't available.
- Staff showed us the resuscitation charts used that had been designed by a nurse, to document all changes to care given in the resuscitation room.
- The escalation route was clear and we reviewed the standard operating procedure for managing emergency demand. Resource escalation action plans (REAP) were used from level 1 to level 6 demand. It was clear from the actions contained within the site co-ordinators meeting documentation that staff understood the policy and the escalation routes. On reviewing incident forms on one occasion consultants within the department were concerned that the department was unsafe due to capacity issues and escalated at level 6 REAP alert. The management team at the time downgraded this alert to level 5.
- Staff told us that capacity was an issue in the department and patients were often in corridors due to no cubicles being available. We reviewed incident forms and found that on one occasion 15 patients were waiting in chairs in the corridors and on another occasion a patient couldn't be treated in a cubicle as none existed; on another occasion 30 patients were in the department waiting for beds.
- Triage was used and nurse practitioners, nurses who had undergone extended training were available to see patients, early senior review or Rapid Assessment Treatment (RATs) models were not used. Nursing staff had an initial assessment and treatment area; however no senior clinicians were based in this area.

Nursing staffing

- One of the must do's from the care quality commission 2014 reports was to ensure there are always sufficient

numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner. Staff told us that recruitment at Pinderfields ED had not encountered any problems.

- No best practice tool is currently available for EDs. The trust had recently undertaken a staffing establishment exercise in relation to staffing ED, as the trust Director of Nursing had been a member on the NICE national working group establishing the staffing ratios for ED's. Pinderfields had scoped staffing requirements in line with one nurse to four patients, and one to one nurse or two to one patient in resuscitation areas as described in the draft NICE safer staffing in ED guidelines however at the point of inspection this document had not been published, so the staffing establishments had not been implemented.
- Current established staffing levels were agreed as 16 nursing staff to be on duty in the morning (10 qualified, main department and two Paediatric nurses and four healthcare assistants), 10 nursing staff for the afternoon shift (10 qualified, main department and three paediatric nurses until 9.30pm and four healthcare assistants). On the night shift there are eight qualified nurses, two qualified nurses on twilight shift and four HCAs.
- The department was non-compliant to Paediatric trained ratios overnight, as qualified children's nurses were not on duty, however staff told us that general nurses had completed a post-registration children's nursing module at a local university.
- Staff we spoke to told us they felt that due to the increased acuity of patients and length of time patients now spent in department, there established staffing levels were not appropriate.
- When we compared the staffing levels to attendances it was noted that at the Pinderfields site staffing was higher than at the Dewsbury site.
- There were band 5 staff nurse rotational posts between Pinderfields and Dewsbury ED's. Within the urgent care improvement programme this was noted it was to be extended to other grades of staff. The rotation was developed to increase and maintain nursing staff core skills, but also to help with recruitment.
- Recently the trust had commenced agency bookings through a different agency and staff said that this had increased the competency of staff as they were often staff who work in Mid Yorkshire trust, or work in another ED department often at a senior level. Staff had developed an agency checklist for nurses if it is their first time in the ED department.
- The use of overtime for the trust has just been recently agreed in the weeks leading up to inspection.
- On the day of inspection the department was not fully staffed. On reviewing three further days over the previous two months off duty (9 shifts) we found that only one shift was fully staffed as establishment.
- Sickness rates for nursing staff were 3.48% (April 2015) which was lower than the England average of 4.81% (July to September 2014). It had been as high as 6.64% in the previous 6 month period.
- Nursing staff shifts were staggered throughout the day to ensure that there were sufficient numbers at the times of peak demand. Handovers were arranged formally twice a day, and informal handovers were held when required.

Medical staffing

- Consultants covered both the Pinderfields and Pontefract sites with 12 WTE consultants employed to support the ED department. 11 of these posts were substantive posts and there were one vacancy at Pinderfields site. The vacancy had been recruited to, with one of the current registrars starting this role in August 2015.
- Occasionally when a divert was in place, the diverting hospital could send a member of medical staff with the patient.
- Consultant recruitment had been difficult and a clinical fellow role had been developed which allowed middle grade doctors to work at Pinderfields ED but have a day a week for specialist interests for example pre-hospital medicine with the ambulance service or medical education, currently five medical staff were undertaking this role.
- Registrars and Junior doctors rotated round the different ED's in the trust. The junior doctors worked on a 19 person rota funded by the Deanery.
- Consultant cover was available 24 hours a day seven days a week. Consultants were available from 8am until 23.00hrs and provided on call cover during the night. One consultant had a specific lead for paediatric medicine.

Urgent and emergency services

- Sickness rates for medical staff was 0.52% (April 2015) which was lower than the England average for medical staff of 1.12%.
- Medical staff told us about the changes in the department such as the patients increased acuity level and the increased length of time patients were in the department. They felt that established staffing levels were no longer correct. When we compared the staffing levels to attendances it was noted that Pinderfields site staffing was set at three consultants per day with 250-300 attendances whereas at Dewsbury they had two Consultants on duty daily with 250-300 attendances per day.
- Handovers were arranged formally twice a day, and informal handovers were 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, it was last reviewed in May 2015. A lead for major incidents in ED was identified on the Pinderfields site and two nurses were identified as responsible for checking the major incident equipment.
- Staff we spoke to had a clear understanding of their roles and responsibilities with regards to major incidents. Although staff told 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.
- A decontamination tent was available and the ED staff were trained in how to erect the tent. Normal practice was to have non-ED staff able to erect the tent as in this type of situation the ED staff are required in the ED department.
- Due to department being busy and the current concerns around flow and congestion, medical staff expressed concerns to us that the department would find it difficult to cope with a major incident.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The department had good level of participation in audits of the College of Emergency Medicine (CEM) Standards, however when they were undertaken mixed results were noted and little evidence was available of departmental learning or change from the recommendations or findings. No specific rolling emergency department audit plan existed.

Patient fractured neck of femur 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.

Only 44% of medical staff and 47.5% nursing staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs) in the previous 12 months.

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. Pathways and admissions criteria existed which identified patients that required direct admission to Pinderfields.

Verbal consent was requested prior to any treatment being carried out, however this was not documented. Staff had received appraisal and staff spoke to us about feeling confident about working within departmental competencies.

We observed good relationships between medical and nursing staff 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 for sepsis, stroke, chronic obstructive pulmonary disease (COPD), Asthma, chest pain and fractured neck of femurs (NOF) and were in line with recommended guidance

- In line with national best practice tariffs, the pathway in Mid Yorkshire trusts was to admit patients following a fractured NOF or a stroke to Pinderfields ED. If a patient attended Pontefract or Dewsbury EDs they were transferred to Pinderfields on diagnosis for further treatment.
- The CEM had 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.
- 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 four 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 operated on within the four hour timescale from arrival into ED.
- At Pinderfields patients were admitted to ED with signs of a stroke, a specialist nurse was available 24 hours seven days per week. The specialist nurse met the patient as they were admitted to ED, the patient had a CT scan and immediate transfer to the stoke unit for further treatment was arranged. A video link was also available to the consultant physician if they were not available.
- We were supplied with the division of medicine clinical audit activity report October to December 2014. In the third quarter of 2014, the ED had no clinical audit plans noted, an audit summary was noted on suspected scaphoid fractures. Plans were made for priority audit projects to be the fitting child in ED, mental health in ED and older people assessing with cognitive impairment in ED for the first quarter of 2014/2015.
- We saw the fitting child and the older peoples audit summary document however this only contained the total numbers of patients included and no conclusions as to compliance.
- We were supplied with the presentations from national data vs. Pinderfields we were assured that this covered all sites, however it wasn't clear from the presentation. Recommendations had been made in the conclusions of the national audits however we were unsure whether these are national recommendations and conclusions or trust specific, there was no evidence of how these had been acting upon internally within the trust.
- Staff told us about nursing cross divisional audits were carried out in record keeping, prescription charts, consent, venous thrombosis events (VTE), cardiac arrests, crash trolleys, controlled drugs and non-medical prescribing and nursing documentation, we asked for evidence of audits undertaken but we didn't receive this data.
- Within the three 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.
- We reviewed an audit conducted on sedation in adults (July 2014), the CEM standard is that 100% patients have sedation records maintained the trust audit found that conscious sedation records were only maintained 73% (69 out of 94 occasions).None of the 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 risk 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.
- On checking the trust guideline for the management, maintenance and safety of play equipment if was found to be a document that had not been through approval and trust sign off.
- We were told that the audits were presented at the clinical governance meetings we also reviewed the minutes of the medical divisional group and noted reference to ED; however no specific audit data was presented. The triumvate for ED were also not noted in the attendance for three meetings we reviewed.

Pain relief

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

Nutrition and hydration

- In the 2014 survey of emergency departments, the trust performed about the same as other trusts for the question, “Were you able to get suitable food or drinks when you were in the A&E department?
- Staff told us that a member of domestic staff was 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 was 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.
- There had been a checklist developed for vulnerable patients over 60 years and offering food and drinks was highlighted for checking in this population group.

Patient outcomes

- The department had good level of participation in audits of the College of Emergency Medicine (CEM) Standards, however when they were undertaken mixed results were noted and little evidence was available of departmental learning or change from the recommendations or findings.
- 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 had participated in 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% of total attendances. Pinderfields hospital was higher than the England average on re-attendance rates to ED July 2014 to May 2015with a re-attendance rate of 9%.
- On reviewing clinical governance meeting minutes audit results, transfers to ITU, deaths in department, incidents, claims, complaints the minutes had little narrative to them so we are unaware of any actions taken by Pinderfields hospital as a result of the evidence discussed.

Competent staff

- Appraisals of both medical and nursing staff were undertaken. The trust reported that 90% of nursing staff on the Pinderfields site had received their appraisals.
- We received information that newly qualified staff were unable to get competencies signed off due to the high numbers of patients in the department. When we talked to staff none of them made reference to this and on further questioning, 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.
- Nursing staff we spoke with felt well inducted into the department and well supported, staff felt able to raise concerns when they need to.
- Staff told us that all staff were paediatric life support trained, and had attended a children’s nursing course at a local university, however we saw no data to corroborate this.
- Nurse practitioners were trained to treat injury and not illness, following the inspection the trust confirmed that some of the practioners were also non-medical prescribers.

- Staff explained to us the new band 5 staff nurse rotation programme between the three EDs which ensure competencies were maintained in the different pathways. As a result of the band 5 rotation scheme plans were 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.

Multidisciplinary working

- There were examples of internal MDT working. During our attendance at a bed management meeting we noted an organised format to the meeting, with key decisions been made in an effective manner. The current REAP level was discussed; the numbers of patients in the ED department, the current waiting times and the number of breaches were discussed. Also discussed was if there was a hospital divert in place, 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 provided mental health advice and guidance 24 hours, seven days a week. Staff felt this had improved 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 told us about the Admissions Avoidance Team, a team which enables rapid access GPs and community matron where the aim is to get patients home quickly and safely with the support in place they require.
- There was access for patients to the drug and alcohol liaison services and a specific teenage section of this team. There was also a child and adolescent mental health team who they could refer patients to.
- A chest pain assessment specialist nurse attended the ED to review patients who have chest pain.
- From resuscitation direct access was available for patients to radiology, CT and MRI scanning facilities.
- Ambulance crews told us that the staff were all very good, but they are very busy and this affected patient care. Medical staff reported to us that the recently opened Ambulatory Care Unit has made a difference to flow in the department.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week. The departments Children's ED was also open until 9.30pm each day; however children could still access services 24hours a day in the main department.

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; however no incident forms had been completed about this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patient's consent being obtained before care was delivered.
- Staff spoke to us about their knowledge and experience of MCA and DoLS, staff were aware of procedures for gaining consent and the need for referrals where required.
- Staff had accessed training on MCA level 1, 2 and 3 compliance data supplied to us by the trust showed low levels of training compliance 47.5% for nursing staff and medical staff at 44%.

- 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 12 months. 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 10-16 hours since attendance. A large number of staff expressed concern over the overcrowding in the department and that the department at times felt unsafe.

The target for ambulance handover times is for handover to be achieved within 15 minutes, data supplied by the trust indicated that in the previous two months Pinderfields had achieved this for 75.15% of handovers in May 2015 and 66.46% of handovers in April 2015. 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.

Service planning and delivery to meet the needs of local people

- The number of patients attending Pinderfields ED had remained relatively static with on average 7979 every month July 2014 to May 2015 peak attendance was seen in July 2014 with 8559 attendances and lowest attendance of 7091 seen in Feb 2015. Paediatric admissions had increased from annual total of 19,645 in 2013 to 20,319 in 2014; the first five months of 2015 there were 8444 paediatric patients.
- 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 were aware of the population they serve and the ethnically diverse needs that they require.

Meeting people's individual needs

- A dedicated Paediatric area was open between 9am until 9.30pm daily. Staff spoke to us about their preference to see children in the children's ED as from 9.30pm paediatrics were seen in the main ED. The Paediatric ED department saw patients below the age of 18 years and it had its own waiting area. It had seven cubicles with curtains and two enclosed rooms, one for triage and one private room. The triage room had only a small children's trolley which would have been too small for an older child.
- Paediatric admissions continue after 9.30pm at a rate of two an hour up to 12 midnight. Through the night on average 5- 6 children attended the department. Medical staff were very concerned about the department closing at night. The Head of Clinical (HoC) informed us that a business case was currently developed to extend the working hours until midnight. In phase two of the 2017 developments it was planned for the paediatric ED to be open 24 hours a day 7 days per week.
- We observed there were no posters which were aimed directly at children and young people to encourage them to access to services.
- The wards could view on the IT system the details of patients who were due to be transferred from ED. There was a symbol present on the IT system which alerted the ward staff if the patient required a pressure relieving mattress.
- Patients we talked to were satisfied with the care they received, they spoke to us about nursing staff keeping them informed and understanding their plan of care.

- 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 demonstrated the comfort rounds given to patients, during the inspection we saw evidence of the CCTV round was undertaken.
- A listening to you' board had been developed as a result of the information from the friends and family test results, there was 12 positive points displayed. One of the actions taken as a result of listening was to fit TV screens as a source of information and distraction in the waiting area. These were in place but turned off during our visit, we highlighted this directly to staff.
- Translation services were available. Family and friends cards were also found to be available in other languages. Staff were aware that during the time of the visit it was Ramadan and the need to support cultural needs.
- Information for patients was available with regards to domestic violence.
- Cubicles existed for speciality conditions such as gynaecology, mental health interview room and decontamination following a chemical/ biological exposure.
- There was a consultant ED review clinic 5 days a week, patients would attend this clinic if they had been previously seen in the ED and the consultant wanted to review them at a later date e.g. sprains and people with wounds and dressings applied.
- Two relative rooms and a viewing room existed in the ED located near the resuscitation room, these had excellent facilities. The door to the resuscitation area was on a key pad so relatives couldn't access without support from a member of staff.
- A room was available within the children's emergency department to support mothers who wanted to breastfeed their child in the department.
- The department was currently in the process of building a bariatric cubicle with hoist access from the ceiling to help meet the needs of individual patients.

Access and flow

- The Mid Yorkshire hospitals NHS trust had consistently not achieved the national standard for percentage of patients discharged, admitted or transferred within four hours of arrival to A&E. The figures ranged from 83.2% to 88.6% between December 2014 and May 2015.Pinderfields had not met the 95% standard for the previous 12 months ED ranging from 83.2% to 94.9 % June 2014 to May 2015. Compliance was the worst in the previous six months.
- Data supplied by the trust stated that attendance was on average 7979 patients per month. The total time to initial assessment was currently not being collected
- The total time that patients should wait from arrival to receive treatment is no more than one hour, this data wasn't currently been collected.
- The median amount of time people could expect to spend in ED before being discharges, admitted or transferred between July 2014 and September 2014, all three sites was on average around 125 minutes which was lower than the England average of 136 minutes. However since September 2014 there had been significant changes in the flow of the department due to an agreement to breach the 4 hour standard.
- 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 was recognised by the Department of Health as potentially being an indicator that patients were dissatisfied with the length of time they had 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 staff spoke to us about the numbers of 4 to12 hour breaches and the reasons for these. Staff said they didn't complete individual incident forms for these patients.
- Medical staff spoke to us about patients being in the department up to 15 to 16 hours in total. We reviewed sets of records from one day a week prior to our inspection and found 5 patients who were in the

department 10 hours 29 minutes to 15 hours 27 minutes, one patient was moved to the ward 29 minutes before they breached the 12 hours since decision to admit.

- We received information which highlighted staff concerns about the flow in the department, increased workload and decreased bed base within the hospital. Staff expressed concerns to us that when crowding in the ED occurs the department becomes unsafe, and staff felt this was a genuine patient safety concern. Staff were concerned that dignity and care were being compromised due to patients being in the department for long periods and the department being crowded. On reviewing incident forms we noted one incident in which staff documented that they could not carry out personal cares or toileting due to the increased workload and overcrowding.
- The target for ambulance handover times is for handover to be achieved within15 minutes; data supplied by the trust indicated that in the previous two months Pinderfields had achieved this for 75.15% of handovers in May 2015 and 66.46% of handovers in April 2015.
- 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 are not available within the hospital; to transfer patients into, therefore, the patient remains in ED until the bed is available. This is potentially an impact for overcrowding in an ED department. Staff told us this was happening more frequently. When exit block occurred staff cared for patients on beds throughout the ED in normal cubicles. However staff assured us that even though a patient was on a bed the timings in ED were still recorded.
- When exit block occurs. Staff also spoke to us about asking speciality doctors for help in the department such as the paediatricians and ear, nose and throat medical staff.
- Ambulance crews we spoke to told us that on the day of inspection receptionist staff were located in the main department from 11am until 11pm, ambulance crews told us that this is not always the case. They did express that having a receptionist in the department expedite the handover time. When the receptionist wasn’t in the department we witnessed ambulance crews having to split up and one wait to book the patient in, this meant the crew was single manned with the patient and was often unable to place them on a trolley.
- Ambulance crews we spoke to talked about a complex and complicated handover process which was not consistent over the three sites in the trust.
- Staff used the communal hospitals discharge lounge during its opening hours, however this area only takes one bed bound patient. Whilst reviewing incident data it was noted that a patient was discharged from the discharge lounge at 1.40am.
- To deal with the increased capacity within the department staff in the area flex, bays and rooms to adapt to the increased capacity. We reviewed incident reports where this had occurred and two bedded cubicles held three patients on trolleys and a four bedded area held 5 patients. This department, cubicle and room sizes have been designed and build as per national specifications for emergency departments. Increased risk occur when trying to put two resuscitation patients in a cubicle designed for one, and three patients in cubicles designed for two.
- Initial assessment rooms were available and after triage staff used these areas for immediate treatment.
- Receptionist were available, and from 11am receptionists are based on the main nurse base until 11 pm, this was to help book ambulances in and to book transfers out. Ambulance staff we spoke to told us the receptionist was not always available on this desk, and when they were not a member of ambulance staff has to wait to hand over in the ED queue which delayed the handover.
- Internal hospital diverts often occur in the trust. This is where one hospital was suffering overcrowding in the ED and transfers all admissions to another hospital within the trust. These diverts could be for GP referrals who had requested for the patient to go to ED or from the ambulance service. A full divert was in place during the day of our first visit to Dewsbury. 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, assessment and treatment time issues.

- 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 the medical team.
- When reviewing incident forms we noted that this approach was not always consistent, on two occasions ambulatory care refused the admission of a patient. Ten incidents were noted to be classified as inappropriate GP admissions, and on another occasion 24 GP admissions were in the ED awaiting assessment.
- Staff spoke to us about clear plans for escalation and were aware of how to ask for help when the department was busy this included asking paediatricians to attend the department, referrals directly to speciality areas.
- All staff expressed to us that on the day we visited, the days attendance figures were unusual and "felt abnormal". During the inspection we saw no issues with flow, congestion or delayed ambulances handover. Staff we spoke to expressed general concerns about flow and congestion in ED, medical staff expressed concerns about patients being located on trolleys in corridors at 3am.
- We reviewed information supplied by the trust that gave details of the number of diverts. 19 internal diverts mixed between GP and blue light diverts had occurred in the three months period April 2014-June 2104 with most of these diverts (17out of 19) being diverts into Dewsbury
- The ED co-coordinator completed a breach report at the handover of each shift.

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 was gained, responded to and used as learning within the department.
- Staff spoke to us about complaints and a recent piece of work that had been carried out in regards to staff attitude and seating in the waiting room. They also spoke to us about a child with complex care needs and due to the family complaining the child now had a plan for direct entry to the paediatric ward, where staff were knowledgeable about the child's needs.
- We reviewed seven 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 the same complaint happening again.

Are urgent and emergency services well-led?

Requires improvement

During the inspection it was clear not all staff understood the 2017 vision for the three emergency departments. Key actions and performance requirements to be completed within that quarter were identified, however some status of these actions were indicated with red and amber indicating that not all actions had been completed within the timescale.

No robust clinical governance structure occurred through the three EDs, Pontefract and Pinderfields held meetings together and Dewsbury held a separate meeting. These meetings were not well attended or documented and it was difficult to see what actions were required.

Nursing staff from the three sites met regularly to discuss issues and concerns. All staff spoke highly of their colleagues. Visibility of the senior management team on the Pinderfields site was good

Vision and strategy for this service

- The Mid Yorkshire NHS trust had introduced a set of core values, during our discussions with staff; staff did not make reference to the values.
- Senior staff told us the vision for the department was to streamline services within ED at Pinderfields and to enable admission of the patient into the correct place. However, not all staff could share the vision for the department with us.
- We reviewed the urgent care improvement programme, which had specific detailed work for the future development of the ED and the relaunch of rapid assessment strategies and ambulance handover paths ways. Key actions and performance requirements to be completed within that quarter were identified, however some status of these actions were indicated with red and amber indicating that not all actions had been completed within the timescale.

Governance, risk management and quality measurement

- A clinical governance structure was in place on the Pinderfields ED site, as ED was part of the division of medicine and their governance meetings fed into the division of medicine governance meeting.
- The ED held multi-disciplinary group governance meetings, incidents, complaints, clinical audit data clinical issues, transfers, deaths and claims were reported. Little narrative was available about discussions or actions. Issues only relating to Pinderfields and Pontefract site were discussed.
- We reviewed two sets of minutes poor attendance was noted.
- Minutes from the Dewsbury site Governance meetings were not discussed.
- No robust governance structure existed for the three EDs at the trust. A computer programme was shared to store their governance minutes, but no formal mechanism existed for shared governance on all three sites.
- Senior nursing staff 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, and one specific risk at Pinderfields regarding the delay in ambulance handover.
- Learning from incidents was shared internally through the clinical governance meetings. These were attended by medical and senior nursing staff from the Pinderfields and Pontefract ED. Departmental wide (all three sites) learning from incidents was unachieved as there was no formal mechanism existed to disseminate lessons learned throughout the three ED’s.
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Leadership of service

- The three ED sites in trust was headed by a Head of Service (HoC), a matron and a patient services manager, these staff were all based on the Pinderfields site, the HoC role was 50% clinical and 50% non-clinical.
- The matron was aware of visibility being an issue when covering three sites. Each of the three sites had a lead nurse and a lead paediatric nurse was available for all three sites, the paediatric lead nurse visited every ED once a week.
- Medical staff spoke to us about the current levels of stress on nursing and medical staff due to the current capacity issues.

Culture within the service

- We found there was an open culture in the ED and staff were not afraid to express concerns informally or formally.
- Staff spoke to us about the ED team a general feeling of a positive moral in nursing staff with a good support network; however the same was not discussed in relation to medical staff.
- Staff reported to us good working relationship with the Pontefract and Dewsbury sites.
- Staff spoke about their worries in the department and about the length of stay of patients and patient safety concerns. They were concerned that it had become ‘the norm’ to have patients on beds in the department between 4 and 12 hours. Staff spoke about their proudness of the team having to work in a difficult environment in relation to the flexing of beds.

Medical care (including older people's care)

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
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. Pinderfields General Hospital in Wakefield has 13 medical wards, including an acute assessment unit (AAU/G12), a coronary care unit (CCU) and an acute care respiratory unit (ACU). The medical division included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, haematology, neurology, spinal injury 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 six wards 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 inadequate. We rated safety and being well-led, effectiveness and being responsive were rated as requires improvements and caring was found to be good. This inspection took place on the 23, 24 25 June 2015 and 3 July 2015 and was part of an announced focused inspection to follow up the outstanding requirement from the previous inspection.

Following the announced inspection in June 2015 CQC received a number of concerns and on further analysis of other evidence an unannounced focussed inspection took place on the 25 August 2015 on Gates 20, 41, 42 and 43. The focus of the inspection was staffing levels, missed patient care and poor experiences of care. At the inspection we had serious concerns regarding the registered nurse staffing levels on Gates 20, 41, 42 and 43 which had impacted on the care patients received.

After the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards. These included utilising staff within corporate nursing teams to support the wards each day with discharge planning and supporting patients with their nutritional needs. We saw the trust had developed rota's to identify which staff would support which ward.

We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward. Staff we spoke with confirmed the additional support they had been receiving since our unannounced inspection on 25 August 2015.

Medical care (including older people's care)

Summary of findings

Overall we rated the service as requires improvement. We rated safety as inadequate, effective, caring and well-led as requires improvement and responsive as good.

Overall we rated the safety domain as inadequate. We had serious concerns regarding the registered nurse staffing levels particularly on Gates 20, 41, 42 and 43 at the unannounced inspection which had impacted on the care patients received. We found the assessment and completion of risk assessments in relation to falls were not always completed fully as a result we found patients did not always get the level of care and support they needed. There were gaps in medication administration and oxygen therapy had not been prescribed. On Gate 41 the fridge temperature for 23 out of the 24 days was recorded as exceeding 8 degrees centigrade. 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 the service as requiring improvement for being caring. Patients and relatives told us care was good but sometimes staff were too busy to support them. Some patients told us they had to wait unreasonable amounts of time for their call bells to be answered. We observed during our inspection two members of staff speaking with patients in an unkind and disrespectful manner on both occasions we brought this to the attention of senior managers in the trust.

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 and respiratory medical staff were assigned to these patients to ensure they had an appropriate medical review. We found the service had specialist roles to support people's individual needs which included respiratory specialist nurse and a learning disability nurse Gate 43 had been designed as a dementia friendly ward and on Gate 41 the ward was developing a suite of two 'Family Support Rooms' which were designated to care for patients who were end of life or otherwise required family members to stay with them overnight. The rooms would have a pull out bed for relatives, a welcome pack and drinks making facility. They aimed to create a 'home from home' environment for the patient. 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 requiring improvement for being well-led. Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Following the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information which detailed the immediate, short-term and longer term actions they were going to take to make the improvements that were needed. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards. We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward. Generally staff told us they felt well supported by their line managers and were able to escalate concerns in the knowledge that they would be listened to. Some staff told us there had been frequent changes to their line manager and they would welcome stability.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Overall we rated the safety domain as inadequate. We had serious concerns regarding the registered nurse staffing levels particularly on Gates 20, 41, 42 and 43 at the unannounced inspection which had impacted on the care patients received.

We found the assessment and completion of risk assessments in relation to falls were not always completed fully as a result we found patients did not always get the level of care and support they needed.

There were gaps in medication administration and oxygen therapy had not been prescribed. On Gate 41 the fridge temperature for 23 out of the 24 days was recorded as exceeding 8 degrees centigrade.

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.
- Senior staff told us once incidents have been investigated, the action plan arising was shared with staff at the daily safety huddle. The safety huddle was a multidisciplinary meeting involving all staff providing care on the ward. We were told action plan was also discussed at the monthly nursing meeting.
- Staff on Gate 41 told us they were aware that a never event had occurred on the ward and as a result all staff had been on medicines management training and further training in the correct way to administer controlled drugs.
- Matrons told us in response to a serious incident regarding the inappropriate restraint of a patient on Gate 43; this had been discussed with all staff at the safety briefing and also at the monthly team meeting. They said that staff were all made aware of the relevant policy and how to implement it in practice.
- On the wards we saw evidence in the minutes of recent team meetings of feedback from incidents and shared learning.
- Staff were encouraged to complete an incident form when staffing fell below the minimum safe staffing levels. Staff also told us that they were encouraged to report near misses so that they could learn from them.
- One nurse was able to give an example of how an incident led to a change in practice on the ward. A nurse had initially failed to attempt to resuscitate a patient as they did not have their handover sheet with them and was unsure if the patient was not for resuscitation. Another nurse escalated that this patient was for resuscitation and this was then attempted. As a result of this incident the nurse repeated resuscitation training and the details of patients with Do Not Resuscitate were now communicated to staff at the safety briefing at the start of every shift.

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 displayed on a notice board on A2 what staff had done to prevent falls which included: an identified falls link nurse, identification of risk level of patients at handover, request additional support seven days per week, changed the position of the base for nurses on a night shift and identified the cause of agitation and treated early.

- We saw safety thermometer information displayed on the communication board on each of the wards we visited. For example we saw on Gate 20 it had been 61 days since the last category three pressure ulcers. On discussion with the matron they told us that the patient had been admitted with this pressure ulcer and that despite being on a district nurse caseload this had not been reported prior to admission.
- On Gate 41 we found it had been 50 days since the last category three or four pressure ulcer and nine days since the last fall with harm (seven falls were recorded for June 2015).

Cleanliness, infection control and hygiene

- We found the medical wards were clean and well maintained. There were policies and procedures in place to ensure that any patients with an infection were managed appropriately, including barrier nursing procedures where applicable.
- Personal protective equipment and alcohol hand gel was available at the entrance to, and throughout all the wards we observed.
- We found on Gate 41 there were two patients with hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) infections. We were told at the time of inspection a post infection review was being carried out. The ward had been put under “special measures” and had an action plan to follow to prevent further cross infection.
- We reviewed training information which showed 88% of staff had completed aseptic non touch technique (ANTT) training.
- Nurses on Gate 42 told us they had previously been carrying out daily hand hygiene audits. The ward had been in special measures due to the development of ward acquired Methicillin-resistant Staphylococcus aureus (MRSA) infections. According to staff no further cases had occurred recently.
- During our visit on Gate 41 we saw a commode which had faeces on the underside; a green clean sticker was attached which was dated 24/06/15 at 11:05. We brought this to the attention of a member of staff who addressed the issue immediately.
- On Gate 20 patient care trolleys were stored on corridors. These were untidy and contained multi patient use items such as toiletries.

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. 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.
- A member of staff on G41 contacted the medical physics department. The staff member told us that they had been advised that the system had changed and that stickers were no longer applied to medical devices following servicing.
- To check this staff member had given the asset number of the ward bladder scanner which did not have any servicing evidence attached in order to ascertain the service date. It was confirmed by the medical physics department that this was last serviced on 09/06/14. This item had a yearly service interval.
- 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 Gates 20, 41 and A2

Medicines

- Staff on some wards told us medicine management assessments were completed and there was a handover of prescription charts between shifts to avoid medication errors.
- We were informed by staff where concerns or errors had occurred staff undertook further medicines management training and this had to be completed before they were allowed to take part in further medication rounds. This was confirmed during interviews with the chief pharmacist.
- On Gate 41 we observed the 8.00am morning drugs round was still being carried out at 11.35am by two nurses. Staff told us that this was due to them being asked to prioritise discharges because of bed pressures.
- On Gate 41 medication fridge temperatures had been recorded daily in June. On 23 out of 24 days the temperature had exceeded 8 degrees centigrade. There was no evidence to indicate that any action had been taken in relation to this.
- We saw a patient on oxygen on gate 41; we reviewed the patient's medication chart and found this had not been prescribed.
- We were told that a pharmacist visits A2 five times per week and that the visits focus on all aspects of medicines optimisation, including medicines reconciliation, for all patients.
- We looked at ten medication charts on A2 and found: three charts had gaps in administration, nine had evidence of pharmacy reconciliation and one chart had no evidence of reconciliation.
- Of the charts that had been reconciled six charts had evidence of pharmacist / technician reconciliation within 24hrs, three charts evidenced that reconciliation had taken place between three- four days after admission and this was over a weekend period.
- We reviewed 10 medication charts on Gate 20 and found: four were fully completed, four had gaps in administration, three patients were on oxygen and this was either not prescribed on the chart or the prescription was not fully completed.

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

- Staff told us that they had received mandatory training which incorporated the required training such as resuscitation and moving and handling.
- 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.
- We were able to confirm this on Gate 41 and saw the training information held on the ward correlated with the trust information. However we saw information held on Gate 20 for mandatory training showed varying compliance.
- We were told by the ward manager that by the 28th July 2015 mandatory training would be 100% for staff on G43.

Assessing and responding to patient risk

- The trust followed the National Institute for Health and Care Excellence (NICE) guidance to identify deteriorating patients. Electronic monitoring systems helped staff to recognise when patients were deteriorating. The system included prompts and advice to staff on what actions were needed.

- The trust used an electronic observation recording tool (Vital Pac). This allowed staff to improve the monitoring of whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating.
- We reviewed 11 patient records on the wards and found that not all risk assessments had been fully completed. Pressure ulcer risk assessments documented that patients had skin damage and that regular skin checks should be carried out however there was little evidence of actions taken for patients who were identified as being at increased risk of pressure sores.
- We saw in records we reviewed that falls assessments indicated that seven patients were at risk of falls however only four had care plans in place.
- On Gates 41 and 43 we saw patients high risk patients were cohorted in to high visibility bays, sensor care equipment was used and a constant staff presence was maintained to reduce the risk of falls
- We were told that A2, Gates 41 and 42 had twice daily safety briefings for staff. The brief included staffing levels, unwell patients, falls risks, infection risks, pressure sores, patients with forget-me-nots, patients with Deprivation of Liberty Safeguards (DoLS).
- We were shown a comprehensive selection of audit tools that were used on G43 to monitor compliance with the following: falls assessment, patient identification, pressure ulcer risk, daily readiness assurance (ward environment checklist), basic nursing care checklist, catheter care and nutrition. We were told that a minimum of five audits per week were performed.

Unannounced focussed inspection of 25 August 2015

- When we visited the wards for the unannounced focussed inspection on 25 august 2015 we saw there was continued concerns regarding the assessment and completion of risk assessments in relation to falls.
- On 25 August 2015 we found on there were a number of patients who had been identified as requiring one to one care. For example on Gate 42 there were ten patients requiring one to one care and on Gate 43 there were two patients who required one to one care.
- On Gate 43 we found one patient who had been identified as requiring one to one care had not received one to one care and had fallen and sustained an injury. Staff had identified this incident as avoidable harm. When we spoke to staff they were not clear if one to one care had been arranged for the following night.
- We escalated our concerns to senior nursing staff and asked that they reviewed all patients identified as a high risk of falls on the wards we visited. Following the inspection the trust provided information that showed all the patients at high risk of falls had had appropriate risk assessments and plans of care put in place.
- For another patient who had a pressure ulcer we saw there was no information in the care records which indicated the care the patient needed in relation to moving and handling to prevent any deterioration of the pressure ulcer.
- During the inspection we reviewed intentional rounding documentation for two patients on Gate 20. There was no documented evidence that the patients had been reviewed since 5am which was six hours previously.
- On Gate 42 we observed staff completing the intentional rounding record with no conversation with the patient, and completed the documentation outside of their room.

Unannounced focussed inspection of 22 September 2015

- Following the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward.
- The trust provided information to CQC which highlighted what immediate actions they had taken to protect patients from the risk of harm.
- These included focussed management support from matrons and patient service managers to provide support to each ward, daily consultant board rounds to ensure patient management plans were in place and being delivered. In addition regular assurance checks on the quality of patient care had been implemented by means of daily ward manager checklist and twice weekly matron checks.
- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We reviewed eight falls risk assessments and found they were completed fully and the agreed levels of interventions were signed off by Matrons and ward managers.
- However we did find for three patients on Gate 20 and 42 there was no specific instructions for how frequently

blood glucose monitoring should be undertaken. For example in one record there was no specified times to record blood sugars and we saw they had been recorded at 6.30am, 7.45am, 10.30am, 17.35 and 21.50..

Nursing staffing

- Across the medical wards we were told that the safer staffing acuity tool was used daily to assess staffing needs against patient dependency and acuity. Band 6 and 7 nurses input staffing numbers into this tool daily. The senior nurse for quality led this and the information from the acuity tool informed the bed meeting.
- Matrons we spoke with told us that sometimes the Trust runs services on minimum staffing levels. Staff were offered overtime to cover the shortfall. A recruitment drive including international recruitment was on-going to address this.
- Matrons informed us that the established number of staff was based on a nurse to patient ratio of 1 to 8. A staffing assessment (SBAR) was also used each day to review staffing across each ward, hospital and across the trust.
- Band 6 staff told us that safety guardians were rostered on duty to reduce the level of patient falls. Safety guardians were trained and supported patients who were at risk of falling. We observed safety guardians assisting patients on Gates 41 and 43.
- The trust provided information prior to the inspection which showed that in January 2015 there was a vacancy rate of 11.54% on Gate 20, neurology had a vacancy rate of 3.33%, Gate 41 vacancy rate was 8% and on Gate 42 it was 7.69%.
- We reviewed information the Safe Nurse and Midwifery Staffing: public board paper for May and July 2015. We saw within the Division of Medicine the vacancy position in October 2014 was 37.60 WTE and had steadily increased month on month to 16% or 74.95 WTE in April 2015. In July 2015 the vacancy rate across the division was 81.52 wte (18.3%) this had increased from the April 2015 position.

A2

- A2 had 39 beds the unit comprised of a hyper acute stroke unit (HASU) with two four bedded bays and three side wards, 12 stroke rehabilitation beds and 16 neurology beds.
- A notice board on the Gate A2 displayed Safe Staffing information. The planned level of staffing for the day shift was seven registered nurses and five health care assistants and we saw the actual number on duty met the planned numbers. The planned level of staffing for the night shift was four registered nurses and two health care assistants and we saw the actual numbers for the night shit met the planned numbers. We were told that, in addition to the planned staffing the unit used Safety Guardians with 90% fill rate.
- There were also 5.8 wte stroke nurses and they provided 24hr cover seven days per week.
- Some staff we spoke with on A2 told us that staffing was an issue. They said the Hyper-acute stroke beds were generally well staffed but the less acute side of the ward often suffered.
- We observed an evening handover on A2. Staff separated into three teams with each team receiving the handover for their patients. The staff on duty were as follows
  - HASU (2 x 4 bed bays and 3 side rooms) – two RN's
  - Neurology (12 beds) one RN and one HCA
  - Stroke rehabilitation (16 beds – 1 empty at time of handover) one RN and one HCA.
- We observed a comprehensive handover of the stroke rehabilitation unit patients. During the handover medication charts were checked for any gaps and omissions. The ICE reporting system was checked for any updated results for patients.
- Staff told us that a brief handover between team members took place when cover for breaks was required. During the handover we could hear buzzers sounding for a considerable amount of time. It was not possible to identify if this had been a single buzzer or multiple.

Gate 31a

- On Ward 31a (the winter pressures ward) we saw there were two registered nurses and three health care assistants compared to a planned number of three registered nurses and two health care assistants during the day.
- At night the staffing levels were two registered nurses and three health care assistants, the same as the planned numbers. This was to care for 21 patients. The ward sister informed us that staff shortages were escalated to the on call staffing bleep holder.

Gate 20

- We saw information that showed there was a planned number of six registered nurses on day shifts and four registered nurses on night shifts.
- On Gate 20 we found there was a matron based on the ward however they were also responsible for a ward at Dewsbury Hospital. There was no band 7 ward manager in post on the ward. We were told that all band 5 vacancies were filled but some staff was not yet in post.
- Staff on the ward reported that minimum staffing levels were frequently not achieved and a number of staff was new to post.
- Gate 20 was a very large ward with a significant 'footprint' there was one nurse coordinating the ward. Two of the bays were used for patients at high risk of falls; sensor care equipment was also used. Staff told us each morning all staff attended a patient safety briefing.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 11 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 15 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in April 2015 we saw there were five night shifts with only two registered nurses on duty and four night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 18 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 11 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in May 2015 we saw there were two night shifts with only two registered nurses on duty and three night shifts with three registered nurses against a planned number of four registered nurses.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 nine day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 16 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in June 2015 we saw there were one night shift with only two registered nurses on duty and two night shifts with three registered nurses against a planned number of four registered nurses.

Gate 20 Acute Respiratory care unit (ARCU)

- On Gate 20 ARCU minimum safe staffing levels were four RN's on days and nights because the unit provided care and treatment for level two patients who required non-invasive ventilation (NIV). Staff told us that the unit was predominantly full.
- Staff told us that on the day of inspection there were four RN's on duty but that the usual staffing levels were three RN's on days and three RN's plus one HCA on nights. Staff reported that when they had four RN's one would be moved.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 there were five day shifts that met the planned numbers of staffing.
- We saw there was two day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 23 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in April 2015 we saw there were one night shift with only two registered nurses on duty and 29 night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 11 day shifts that met the planned numbers of staffing. In addition we saw there were 21 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in May 2015 we saw there were two night shifts which met planned numbers of registered nurses there was one night shift with only two registered nurses on duty. There were 28 night shifts with three registered nurses against a planned number of four registered nurses.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 two day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 25 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in June 2015 we saw for the whole of the month there were three registered nurses against a planned number of four registered nurses.

Gate 41

- During our inspection staffing levels on Gate 41 were running on minimum levels of four registered nurses and four health care assistants compared to an establishment of five registered nurses and four health care assistants.
- We were told that Gate 41 normally used bank and agency staff who had regularly worked on the ward. One of the band 6's told us it was easier to obtain bank staff on weekends and evenings therefore they tried to ensure staffing planned for the weekday shifts was more robust.
- Staff we spoke to on Gate 41 said that staffing was an issue. They were never fully staffed as someone was always taken to go onto another ward. On the day of inspection they were short of one registered nurse.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 four day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 23 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in April 2015 we saw there were six night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 nine day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 18 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in May 2015 we saw there were eight night shifts with three registered nurses against a planned number of four registered nurses.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 eight day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 21 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in June 2015 we saw there was seven night shifts with three registered nurses against a planned number of four registered nurses

Gate 42

- We saw information that showed there was a planned number of six registered nurses on day shifts and four registered nurses in night shifts.
- Staff on Gate 42 told us that they were always understaffed and if they ever had full staffing levels someone was pulled off to work in another area.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 18 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 11 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in April 2015 we saw there were six night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 13 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 21 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in May 2015 we saw there was one night shift with two registered nurses on duty and there were three night shifts with three registered nurses against a planned number of four registered nurses.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 20 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 14 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in June 2015 we saw there was six night shifts with three registered nurses against a planned number of four registered nurses

Gate 43

- Gate 43 had 41 beds. The planned staffing each day was four teams of one RN and one HCA plus a coordinator. The ward manager was supervisory. The planned Registered Nurse staffing ratio was 1:10 for days and nights.
- We were told that handovers of care occurred twice a day on wards. We observed an evening handover on Gate 43 which provided comprehensive detail on each patient's current conditions and clinical needs. The

handover also contained information about staffing levels for the shift and a safety brief which gave details of falls risks, pressure ulcer risks, patients with infections and unwell patients needing 4 hourly observations.

- Senior staff on Gate 43 told us that they were the equivalent of 5-6 registered nurses down in staffing. They had filled one post and were recruiting further in July. There was also a vacancy of a health care assistant post and plans were in place to interview soon for this.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for May 2015. We saw for April 2015 eight day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 17 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in April 2015 we saw there were one night shift with two registered nurses and five night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information in the Safe Nurse and Midwifery Staffing: public board paper for June 2015. We saw for May 2015 10 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 22 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in May 2015 we saw there was one night shift with two registered nurses on duty and there were two night shifts with three registered nurses against a planned number of four registered nurses.
- In the Safe Nurse and Midwifery Staffing: public board paper for July 2015. We saw for June 2015 14 day shifts for some or part of the day were more than two registered nurses below the planned levels. In addition we saw there were 16 day shifts for some or part of the day were one registered nurse below the planned levels.
- For night shifts in June 2015 we saw there were seven night shifts with three registered nurses against a planned number of four registered nurses.

Discharge Lounge

- We visited the discharge lounge. There were no patients in the unit at the time of our visit. We were told that the unit was staffed from 8am – 8pm four days per week and 10am - 6pm one day per week. The unit operated Monday – Friday. Staffing was one RN and one HCA on each shift.

Unannounced focussed inspection 25 August 2015

- During our unannounced focussed inspection on 25 August 2015 we attended a bed meeting at 12.30 in the hospital and found of the 17 wards at Pinderfields there was six wards below minimum staffing, these were gates 20, 42, 44, AAU, ED, 31b and 10 wards on minimum staffing levels. There was one ward which was staffed to safe staffing levels that day.

Gate 20

- On Gate 20 in July 2015 we saw there were 16 full day shifts and a further eight shifts for part of the day where there was one less than the planned number of registered nurses. We also saw there were seven full day shifts and a further seven shifts for part of the day where there was two less than the planned number of registered nurses.
- For night shifts in July 2015 we saw there were 25 night shifts which met the planned number of registered nurses and six night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information from the 1 August to the day of our inspection on 25 August 2015 and found there was one early shift which met the planned number of registered nurses. There were eight full day shifts and a further four shifts for part of the day where there was one less than the planned number of registered nurses. We also saw there were 12 full day shifts and a further five shifts for part of the day where there was two less than the planned number of registered nurses.
- For night shifts in August 2015 we saw there were 23 night shifts which met the planned number of registered nurses and two night shifts with three registered nurses against a planned number of four registered nurses.

Gate 41

- On Gate 41 in July 2015 we saw there were 16 full day shifts and a further six shifts for part of the day where there was one less than the planned number of registered nurses. We also saw there were nine full day shifts and a further six shifts for part of the day where there was two less than the planned number of registered nurses.
- For night shifts in July 2015 we saw there were 20 night shifts which met the planned number of registered nurses and 11 night shifts with three registered nurses against a planned number of four registered nurses.

- We reviewed information from the 1 August to the day of our inspection on 25 August 2015 we found there was one late shift which met the planned number of registered nurses. There were 18 full day shifts and a one shift for part of the day where there was one less than the planned number of registered nurses. We also saw there were six full day shifts where there was two less than the planned number of registered nurses.
- For night shifts in August 2015 we saw there were 17 night shifts which met the planned number of registered nurses and eight night shifts with three registered nurses against a planned number of four registered nurses.

Gate 42

- On Gate 42 in July 2015 we saw there were five full day shifts where there was one less than the planned number of registered nurses. We also saw there were 26 full day shifts where there was one less than the planned number of registered nurses.
- For night shifts in July 2015 we saw there were 27 night shifts which met the planned number of registered nurses and four night shifts with three registered nurses against a planned number of four registered nurses.
- We reviewed information from the 1 August to the day of our inspection on 25 August 2015 and found there were three full day shifts and a further two shifts for part of the day where there was one less than the planned number of registered nurses. We also saw there were 20 full day shifts and a further two shifts for part of the day where there was one less than the planned number of registered nurses.
- For night shifts in August 2015 we saw there were 22 night shifts which met the planned number of registered nurses and three night shifts with three registered nurses against a planned number of four registered nurses.

Gate 43

- On Gate 43 in July 2015 and found there was one early shift which met the planned number of registered nurses. We saw there were nine full day shifts and a further five shifts for part of the day where there was one less than the planned number of registered nurses. We also saw there were 17 full day and a further four shifts for part of the day shifts where there was two less than the planned number of registered nurses.
- For night shifts in July 2015 we saw there were 26 night shifts which met the planned number of registered nurses and three night shifts with three registered nurses against a planned number of four registered nurses. We saw there was two nights where there were two registered nurses against a planned number of four.
- We reviewed information from the 1 August to the day of our inspection on 25 August 2015 and found there was one day shift which met the planned number of registered nurses. We found there were 11 full day shifts and a further three shifts for part of the day where there was one less than the planned number of registered nurses. We also saw there were 10 full day shifts and a further three shifts for part of the day where there was two less than the planned number of registered nurses.
- For night shifts in August 2015 we saw there were 16 night shifts which met the planned number of registered nurses and nine night shifts with three registered nurses against a planned number of four registered nurses.

Unannounced focussed inspection 22 September 2015

- Following the unannounced inspection we wrote to the trust and asked them to review staffing levels on the wards to ensure safe staffing. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards.
- These included utilising staff within corporate nursing teams to support the wards each day with discharge planning and supporting patients with their nutritional needs. We saw the trust had developed rota's to identify which staff would support which ward.
- The trust was also block booking an additional 12 safety guardians or Health care assistants to support the four wards when we visited on our unannounced inspection we found the additional staff on the wards.
- We were provided with information which showed between 7 to 18 September 2015 94 shifts of safety guardians had been booked and worked and 77 shifts of Health care assistants (HCA's).
- We saw information within the organisational risk assessment which highlighted the increased support to the wards by matrons and patient service managers (PSM's) for example we saw on 11 September 2015 "Matrons (name x 2) have supported Gate 42 this morning and are returning to Gate 41 this afternoon." One of the deputy chief nurses and matron told us the support consisted of "hands-on" patient care.

- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. Staff we spoke confirmed the additional support they had been received since our unannounced inspection on 25 August 2015.

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
- A2 had consultant ward round on Tuesdays and Fridays. A senior physician was available every day. Patients in Hyper-acute stroke beds were seen by the senior physician every day for 72 hours following thrombolysis.
- On A2 we were told that the medical staffing for stroke was as follows seven day consultant cover,
- Seven day registrar cover and 24/7 junior doctor cover. Medical staffing for neurology was as follows seven day consultant cover, 9am-5pm - one registrar for the ward and one registrar for referrals, from 5pm junior doctor cover with registrar level support.
- Medical staff on told us that they felt well supported and that consultant cover was good. They said that there is always someone more senior to discuss something with.

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.
- We also saw the division was also auditing their compliance with NICE guidance for Hip fractures (quality standard 16) this had been due to be completed in March 2015. The results were not available at the time of our inspection.
- 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 informed us that several audits were carried out on wards which included a daily hand hygiene audit, antibiotic prescribing audit, safe care audit, care assurance audit, forget-me-not audit.
- We found monthly matron assurance frameworks audits for each clinical area the audits review medicine management, storage and management of equipment /crash trolleys. Documentation, patient experience and a full review of nursing assessments and care planning.

Nutrition and hydration

- Patients were able to access suitable nutrition and hydration, including special diets during meal times and when these had been pre-planned.
- 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.
- Throughout the inspection on the medical wards we visited we found malnutrition universal screening tool (MUST) was not always completed fully. For example on Gate 20 in four sets of records we found the MUST risk assessments were out of date. On Gate 42 we saw two patients had Malnutrition MUST scores which were not in date and one patient identified as at risk had a poorly completed nutritional care plan.

Unannounced focussed inspection of 25 August 2015 and 22 September 2015

- When we visited the wards for the unannounced focussed inspection on 25 August 2015 we reviewed fluid balance monitoring and nutritional assessments. We found that not all charts were always completed fully.
- On Gate 42 one patient had surgery two days previously and had intravenous fluids in progress and had a urinary catheter. We reviewed the patient records and found the fluid balance chart had not been completed for the 25 August 2015 we found there was no evidence of fluid balance monitoring for previous two days in the patients records. On observation and discussion with staff low urine outputs were identified.
- We reviewed six fluid balance charts for patients on Gates 20 and 42 for 25 August 2015 and found no urine outputs had been recorded.
- During the inspection we observed a doctor speak to a nurse about a patient who had told them they had not passed urine since the day before. The nurse caring for the patient was not aware of this and was going to undertake a bladder scan and observations.
- For one patient on Gate 20 we saw the patient hadn't opened their bowels for five days. In the records we saw staff had asked for a laxative to be prescribed but there was no evidence in the patient's medication records of any such medication being prescribed.
- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We reviewed 14 food and fluid charts and found patients had them for each day however we found these were not always fully completed. For example on one fluid chart we saw the patient had not had a drink recorded on their chart since 9am (this was at 10pm) and they had no recorded urine output until 4pm that day.

Competent staff

- There were formal processes in place to ensure staff had received training, supervision and an annual appraisal. Appraisal rates for staff on Gate 41 were 91% in June 2015 whereas on Gate 20 the rate was 82%.
- We found there was a band 2 competency programmes for staff to complete on Gates 20, 42 and 43. The trust provided information which showed that for band 2 staff on Gates 20 and 42 all eligible staff had completed the competency framework however none of the eligible staff on Gate 43 had completed it.
- We found there were specialist stroke nurses (5.8wte) on A2 which provided 24 hour cover to the unit. There was also a respiratory specialist nurse based on Gate 20 to support the care of patients on there.

Multidisciplinary working

- Staff on Gates 20 and 41 told us that there was good multidisciplinary working between the medical, nursing, health care assistants, physiotherapy, and occupational therapy staff on the ward.
- For example a multidisciplinary meeting was held on A2 every morning to discuss patients on the stroke pathway. This was attended by doctors, nurses and therapists. Speech and language therapists sometimes attend, and on Wednesdays there is a social worker present.

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.
- On Gate 41 100% of staff were up to date with Mental Capacity Act training level 1 and level 3 and 70% with level 2.
- During our inspection we saw a notice board in the corridor on A2 which displayed the contact details and a photograph of the specialist advisor for Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- On A2 we were told that all band 7 and band 6 nurses had participated in a 'master class' Mental Capacity Act (MCA) training and that there was always one of these staff on duty. We found 100% of HCA staff on the unit have had level 1 training and 33 RN's were either booked or have already attended.
- Staff on Gate 41 told us about the availability of a specialist advisor for Mental Capacity Act and DoLS. They did not currently have any patients with a DoLS however they were in discussion with the specialist advisor regarding one patient on the ward.
- Staff we spoke with was able to demonstrate clear understanding of the Mental Capacity Act and how they would complete a DoLS assessment. We observed a laminated flow chart to help staff with Mental Capacity Act assessments.

- We observed a handover on Gate 43 and details of patients with a DoLS were discussed.

Are medical care services caring?

Requires improvement

Overall we rated the service as requiring improvement for being caring. Patients and relatives told us care was good but sometimes staff were too busy to support them. Some patients told us they had to wait unreasonable amounts of time for their call bells to be answered. We observed during our inspection two members of staff speaking with patients in an unkind and disrespectful manner on both occasions we brought this to the attention of senior managers in the trust.

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.
- Patients generally told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner.
- However during our inspection we visited Gate 43 for evening handover and observed a member of staff speaking to a patient in an unkind and disrespectful manner. We raised this with managers at the time of inspection.
- Visitors on Gate 43 told us that their relatives care has been good and that other medical conditions have been sorted out during their stay. They were concerned about staffing levels at weekends and worried that this might lead to deterioration in their relative's condition due to lack of stimulation.
- We saw a notice board on A2 which displayed the results of the Friends and Family test. In May 2015 there had been a response rate of 29% with a score of 100% of patients who would recommend the service they have received to friends and family who need similar treatment or care.
- On Gate 41 we saw information which indicated that the Friends and Family cards response rate was 24.6% with 87.6% of respondents indicating that they were likely or extremely likely to recommend the ward.
- We spoke to a family member of a service user on Gate 20 who told us that the ward staff was 'diligent' and that they were happy with the care received.

Unannounced inspection 25 August 2015

- Some of the patients and relatives we spoke with said the staff was busy and sometimes too busy to do things although they tried their best to support them.
- We spoke with three patients who told us they had had to wait unreasonable time to have call bells answered, or had been told that staff were too busy and would have to come back later.
- Two patients told us it was pointless to ask for help over the lunch time. One patient said "if you need the toilet it's tough as nobody is free to assist."

Unannounced inspection 22 September 2015

- During our unannounced inspection we spoke with seven patients and relatives they all told us they were happy with the care and support they had received on the wards.
- We observed a member of security staff who had been called to assist nursing staff with a patient speaking to the patient in aggressive tone and manner.

Understanding and involvement of patients and those close to them

- A visitor told us that they would have liked more communication from staff about their relative.
- We found in the minutes of Gate 43 monthly staff meeting evidence that relatives of patients had been invited to share their experiences and concerns with staff at the meeting. Details of how the ward had responded to address some of these concerns were also documented in the minutes.
- We spoke to a patient and the relative of a patient with dementia. They told us that staff were caring but that they had not been involved in decisions. The carer told us that the care on the ward had been 'really good' and that buzzers were answered quickly. They said that they had been kept informed by the doctors and felt involved.

- One of the visitors we spoke with told us that they would have liked more communication from staff about their relative.

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 and respiratory medical staff were assigned to these patients to ensure they had an appropriate medical review.

We found the service had specialist roles to support people's individual needs which included respiratory specialist nurse and a learning disability nurse. Gate 43 had been designed as a dementia friendly ward and on Gate 41 the ward was developing a suite of two rooms to care for patients with a learning disability. The rooms would have a pull out bed for relatives, a welcome pack and drinks making facility. They aimed to create a 'home from home' environment for the patient.

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

Access and flow

- At our inspection in July 2014 medical staff told us there were often 20 to 30 medical patients (outliers) on the surgical wards. At this inspection we reviewed data which showed from 1 June to 11 July 2015 indicated 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 Pinderfields there was between two and 11 patients admitted under a medical specialty based on a surgical ward. (For Dewsbury this was between three and 14 and Pontefract there was none.
- We were told that a Respiratory registrar was assigned to see all respiratory outliers from Gate 20 to ensure they had appropriate medical review.
- 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 that HASU took direct admissions for stroke patients to ensure early thrombolysis was achieved. On two occasions since January 2015 this had been performed in A&E due to bed pressures on the HASU. We were told that this was due to medical outliers being on A2
- Staff on Gate 42 informed us patients with a fractured neck of femur were still breaching the 36 hour to theatre time. The trust had appointed an ortho-geriatric nurse for 6 months and this role had improved the time taken to get patients up to the ward from the Emergency Department and to be seen by orthopaedics. There was a protected bed for patients with a fractured neck of femur however we were told that this often gets filled with medical outliers.
- Staff told us that there was a fast response time when a referral was made to the specialist diabetes nurse. Any changes to the insulin prescription were clearly communicated to the nurse in charge of the patients care.
- We found on Gate 20 they had introduced a discharge coordinator after the ward had recognised that the discharge processes had been poor which had led to delayed discharges.
- We spoke to one patient who told us that during a previous admission in August 2014 they had spent nine days in Pinderfields hospital and had moved beds 8 times. We spoke to another patient who told us that they had been moved three times including on one occasion when they were moved at 04:00am.

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.

Medical care (including older people's care)

- 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.
- On Gate 41 the ward was developing a suite of two rooms to care for patients with a learning disability. The rooms would have a pull out bed for relatives, a welcome pack and drinks making facility. They aimed to create a 'home from home' environment for the patient.
- Within the service the "forget me not" system was used to support patients living with dementia. On Gate 41 the forget-me-not sign was displayed above the beds of patients with dementia. We were told that the ward was waiting for the door surrounds to be painted red to highlight toilet facilities for patients.
- We saw on Gate 43 it was a dementia friendly ward. On the day of inspection we observed patients engaging in an afternoon tea party. Tea and cakes were available and music was played for patients to listen to and sing along with. We also observed a reminiscence room which was brightly decorated in a 1960's theme and contained comfortable seating and activities for patients to engage in if they choose. We also saw an 'ideas tree' which contained thoughts on how people with dementia should be treated.

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.
- Staff told us when complaints were made and had been investigated; any learning was shared with staff at the daily safety brief and at monthly team meetings. Staff also told us of the complaints process including duty of candour and feedback mechanisms.
- We reviewed the minutes of the last three team meetings and found that a discussion on complaints was discussed. On Gate 20 a complainant had been invited to attend the team meeting to share their experience.
- We found on Gate 42 staff were aware of four recent complaints about the service. However staff appeared to be unclear about how these were fed back to the team and were not able to give examples of sharing complaints with staff.
- We were told by staff that the Newsletter 'My News' was used to disseminate learning from complaints trust wide.

Are medical care services well-led?

Requires improvement

Overall we rated medical care services as requiring improvement for being well-led. Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Following the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information which detailed the immediate, short-term and longer term actions they were going to take to make the improvements that were needed.

The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards. We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward.

Generally staff told us they felt well supported by their line managers and were able to escalate concerns in the knowledge that they would be listened to. Some staff told us there had been frequent changes to their line manager and they would welcome stability.

Medical care (including older people's care)

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.
- At the unannounced inspection on 22 August 2015 we had serious concerns regarding the registered nurse staffing levels on Gates 20, 41, 42 and 43 which had impacted on the care patients received. For example we found one patient who had been identified as requiring one to one care had not received one to one care and had fallen and sustained an injury. Staff had identified this incident as avoidable harm. When we spoke to staff they were not clear if one to one care had been arranged for the following night. We also had concerns regarding the fluid balance monitoring and nutritional assessments of patients on the ward; we found that not all charts were always fully completed.
- Following the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information which detailed the immediate, short-term and longer term actions they were going to take to make the improvements that were needed.
- The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards. These included utilising staff within corporate nursing teams to support the wards each day with discharge planning and supporting patients with their nutritional needs. We saw the trust had developed rota's to identify which staff would support which ward.
- The trust was also booking an additional 12 safety guardians or health care assistants to support the four wards when we visited on our unannounced inspection we found the additional staff on the wards.
- We saw information within the organisational risk assessment which highlighted the increased support to the wards by matrons and patient service managers (PSM's) for example we saw on 11 September 2015 "Matrons (name x 2) have supported Gate 42 this morning and are returning to Gate 41 this afternoon." One of the deputy chief nurses and matrons told us the support consisted of "hands-on" patient care.
- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward. Staff we spoke with confirmed the additional support they had been receiving since our unannounced inspection on 25 August 2015.
- 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.
- We found on Gate 20 feedback and learning from incidents and complaints was communicated to staff via the bi-monthly Team Meetings. In addition there was also a monthly Senior Nurse Meeting.

Leadership of service

- There had been a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months.
- Some of the matrons continued to cover more than on hospital site which meant they were not always visible at the hospital site.

Medical care (including older people's care)

- Staff on Gate 20 told us that they felt well supported and were able to escalate concerns in the knowledge that they would be listened to. At the time of inspection in June 2015 Gate 20 had been identified as the most improved ward within the division of medicine.
- On Gate 20 the service was using a 'vacant' band 6 post as a development opportunity role for band 5 nurses to rotate in to. However staff reported that a band 7 role would be beneficial on the ward to support the matron who also covered a ward at Dewsbury and District Hospital.
- Staff told us that Gate 20 was 'better than ever' and that 'things had got a lot better'
- We were told that bi monthly team meetings took place on Gate 20 and that these were well attended. Staff was rostered 'on duty' for these events and non-attendance was addressed. The chief executive blog was printed and displayed on Gate 20
- On Gate 41 there had been two changes in the ward manager in the last year. Staff told us their line manager had changed five times in the last two years and that stability was needed on the ward. Band 5 nurses working on Gate 41 said that although they were very busy they felt well supported by more senior nurses and the ward manager.
- We spoke to two student nurses on Gate 41 who said although they sometimes felt they were counted in the staff numbers (because of staff shortages) they had never been asked to do anything outside of their remit or that they were not comfortable with. They felt supported and encouraged to learn.
- On Gate 42 band 6 and band 5 nurses both stated that they felt well supported by the ward manager. Staff said they felt empowered and had been given link nurse roles which they enjoyed.
- We saw across the division employee of the month had been introduced. We observed in the minutes of the monthly team meeting for Gate 43 and saw an employee of the month was awarded. Staff were able to nominate individuals they worked with.
- A matron informed us that team building work has been carried out with staff on Gate 43 to improve morale and staff engagement. They said that sickness levels had been high at approximately 30%-40% and were now reduced to approximately 10%.
- We observed in the minutes of the monthly team meeting for Gate 43 that patient/relative handbook had been developed.
- We saw on A2 team goals for each month (June) were displayed on a notice board. These were being proactive and positive, ensure you are familiar with action plan and comply with development plan for Mental Capacity Act and DoLS.

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. Staff told us generally that management was better and there was more clinical engagement.
- Matrons within the division told us there a general feel amongst staff that the trust was working hard to improve services. Staff told us that they thought there was a focus on continual improvement within the organisation.
- One member of staff told us they "loved" working on the ward. They felt extremely well supported and engaged with holistic care.

Surgery

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

Information about the service

Pinderfields General Hospital provides a range of surgical services, including general surgery, urological and gynaecological surgery, ENT, ophthalmology, day surgery, burns and plastic surgery and interventional radiology is provided by the diagnostic imaging service.. There are approximately 168 surgical inpatient beds and 15 operating theatres.

We visited gates 32, 38, and 40. We also visited the operating theatres and the post anaesthesia care unit (PACU).

We spoke with 17 patients and 43 members of staff, including ward managers, nursing staff, medical staff (both senior and junior grades) and managers. We observed care and treatment and reviewed 13 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 the number of emergency admissions following elective and non-elective admissions. There

remained concerns over waiting times, such as the 18-week referral to treatment times and arrangements for the access and flow of patients on to the wards and theatres.

There were dedicated theatres for emergencies but not all specialties had timely access such as colorectal surgery and it was not clear what plans were in place to accommodate the additional emergency workloads that would be transferred from Dewsbury Hospital.

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, however on some wards we found there were gaps in recording of checks for resuscitation equipment. There were also inconsistencies in completing documentation particularly pressure care assessments. Improvements were required in the layout and facilities on some wards to improve patient experience.

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 was 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 recoding 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.

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. However, some groups of staff said incidents were not consistently reported due to poor feedback and that reporting generated extra work for staff without a positive result.
- 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 Pinderfields Hospital for the period April 2014 to May 2015. There were 25 serious incidents reported for the same period. The majority of these related to pressure ulcers, slips, trips and falls, delayed diagnosis.
- Data for November 2014 to February 2015 showed there were 645 incidents reported for surgery at Pinderfields Hospital. The majority of these were graded as low or no harm and near miss. Actions included improvements in documentation, communication and competency assessments 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.
- Data for June 2015 showed 96% of patients in general surgery had received harm free care.
- Results for VTE risk assessments for April and May 2015 was 99% which was better than the trust target of 95%.
- 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 particular types of incident had occurred in that area.

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.
- 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 target of 2.
- 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 Pinderfields.
- Data for April and May 2015 showed that 97.6% of acute admissions were screened for MRSA against a trust target of 100%.

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 gaps in recording.
- In response to the findings at the last inspection a review of the access and provision of sterile equipment and trays in theatres had been taken to ensure that these were delivered in good time. A cut of time of time of 11am had been introduced to ensure theatre lists were agreed and information shared with sterile services staff to organise trays for the next day’s theatre list which had reduced delays.

Medicines

- 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. We checked the stock balances of CD drugs on ward 33 and these were correctly recorded.
- We observed a medicines round on ward 33. The medicine trolley was left open near the door to single rooms. The nurse also did not observe patients to ensure they had taken their medicines.
- We observed two nurses preparing IV antibiotics in the treatment room. This was done safely.

Records

- Care pathways were in use, for example, patients who had suffered with a fractured neck of femur.
- The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Most records we looked at were completed accurately. However, in nine out of 13 records we found that sections such as care plans were not fully completed and the recording of the frequency of repositioning patients at risk of pressure ulcers was not consistently recorded.

Safeguarding

- Data for June 2015 showed that 100% of staff in the division 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 followed the National Institute for Health and Care Excellence (NICE) guidance to identify deteriorating patients. Electronic monitoring systems helped staff to recognise when patients were deteriorating. The system included prompts and advice to staff on what actions were needed.
- 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 showed some areas had been identified for improvement including swab count pause for all activity to stop (89% compliant), and the theatre team to allow time for pause and not to interrupt (88% complaint). The documentation audit showed 80% of swab counts were correctly recorded.
- Trust data showed that there were no delays for patients in PACU requiring level 2 or 3 high dependency beds at Pinderfields from February to June 2015.
- Escalation plans were in place to ensure patients were transferred from PACU after two hours. Staff said if no beds were available this was raised at the daily bed meetings and referred to site mangers.

Nursing staffing

- For the month of June 2015 there was an increase in registered nurse vacancies in 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.
- 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 trust was actively recruiting to nursing vacancies including the recruitment of student nurses; however these nurses were not available until September 2015 upon qualifying. 32 students had been recruited of these four would take up posts in surgery and six in theatres.
- Following our last inspection which identified shortfalls in staffing on PACU this had improved; two band 6 staff were now in post since January 2015.
- Staffing on the surgical assessment unit had improved since our last inspection. Two remaining vacancies had recently been recruited to. Staffing ratios were one nurse to eight patients which the senior ward manager felt was appropriate to meet patient need.
- A review of theatre staffing was being undertaken by the new manager as the current establishment was based on 13 theatres not the current number of 15 theatres. Theatres continued to run with a high number of agency staff which was approximately a 50% split between permanent and agency staff. Core agency staff was being booked on a three-month basis to provide continuity of care. Theatres had also appointed apprentice health care assistants with the potential to train and develop these staff to progress to band 5 appointments.
- Staff told us the efficiency and timeliness of recruitment and selections procedures had improved since our last inspection.
- The staffing establishment on SSSU was reviewed when the unit became a 23-hour stay unit. Staff said the workload was very unpredictable which meant staff regularly had to change shifts and work flexible but staff were happy to do this. The ward manager was looking at introducing a 12 noon to 11pm shift to provide staff with additional support in the evening as this was busiest time when trying to discharge patients.

Surgical staffing

- Consultant medical staff could be accessed 24 hours a day seven day a week. There was also access to the critical care outreach team for deteriorating patients.
- 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.

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 dedicated theatres for emergencies but not all specialties had timely access such as for colorectal surgery. These issues were raised at the inspection in July 2014 and were yet to be resolved. It was also not clear what plans were in place to accommodate the additional emergency workloads that would be transferred from Dewsbury Hospital to ensure NCEPOD recommendations were met.

Mortality indicators were within expected ranges. Other indicators showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, patients developing pressure ulcers and the 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.

Surgery

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. At this stage it therefore remained 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 trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the trust was better than the expected England average in areas such as patients receiving a bone protection medication, pre-operative assessment by a geriatrician and falls assessment. The trust was worse than the England average for patients being admitted to orthopaedic care within 4 hours (26% compared to a national average of 48%) and surgery within 48 hours; for example, 69% of fractured necks of femur were seen within 48 hours against the national target of 74% and for patients developing pressure ulcers (5.3% against a national average of 3%) The senior team were aware that further work was required to improve in this area, and were looking at processes for organising trauma cases, improving communication between orthopaedics and the ortho-geriatrician and ring fencing beds.
- 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 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.
- Most junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- A first year student nurse spoke positively about their placement on Gate 40. They told us they had a mentor who was very supportive and that they had received a comprehensive induction and introduction to ward.

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%.

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.
- We observed a discussion with a junior doctor and the trust lead for learning disabilities about whether a DOLS was required for a patient. A comprehensive discussion was held over the patient's best interests, mental capacity and the process to follow if the patient didn't want to stay overnight.

Are surgery services caring?

Good

Surgical services were caring. The NHS Friends and Family Test for June 2015 showed the majority of patients would recommend the service. Patients spoke positively about their treatment by clinical staff and the standard of care they had received. However, there were occasions when patients had to wait for support particularly during the night due to workloads on the wards.

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

Compassionate care

- The June 2015 NHS Friends and Family Test inpatient data for surgery showed 83% of patients on SAU, 90% on G33, and 97% on G40 were 'extremely likely' or 'likely' to recommend the service to their family and friends. Data for the same period in Orthopaedics showed 98% of patients on G32a and 100% on G38 would recommend the service to their family and friends.
- Most patients we spoke with were happy with the quality of care they had received. They said that staff worked hard and were busier at night than during the day. Some patients had to wait longer for care at night but most said that the wait was not unreasonable.
- 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

- Patients were kept informed and involved with decisions about their care and treatment when appropriate.
- 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.
- There was information within the care plans to identify whether patients had emotional or mental health problems.
- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.

Surgery

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 and in theatres which was ineffective.

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.
- 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 concerns amongst some members of the consultant body regarding the lack of an NCEPOD list for general surgery. We received mixed messages about the utilisation of theatres to accommodate emergency lists. The surgical management team stated that there was an emergency theatre 24 hours a day for cases undertaken in order of clinical priority using the CEPOD categorisation of acute trauma patients which was decided by surgeons and anaesthetists.
- The management team told us there had been no delays in patients needing immediate access (within an hour) or urgent access (within eight hours) from the theatre management data in quarter three and four of 2014/15. There were four delays for patients (0.2%) in the expedited category (waiting beyond 48 hours).
- We reviewed data from the trust relating to operations which started between 8pm to 8am. Best practice guidance indicates that out of hours operating may result in a poorer outcome for patients. The data showed that the mean number of emergency abdominal procedures performed at Pinderfields out of hours was 21.5 per month. There was no information as to whether or not the emergency lists were consultant led or what the outcome was or to the availability of critical care. A 50% sample (which excluded obstetric, gynaecological, orthopaedic and urological procedures) from 1 June 2014 to 29 January 2015 was checked. 93 general surgical, colorectal and abdominal emergency procedures were identified. 30 of those cases were commenced after midnight (32% of cases) and one case (on 26 and 27 January 2015) had waited 18 hours for a theatre slot.
- The surgical management team informed us that the development of a further four hour weekly session with general surgery for semi acute and urgent patients was being considered. There was also some discussion about the management of patients in a timelier manner by increasing theatre access.
- There was a trauma co-ordinator on duty each day that was responsible for managing and balancing the trauma and acute workload and reported this through to the bed meeting daily via a RAG rated system. This ensured that any spaces in elective theatres were utilised to manage the workload effectively and escalate when the demand was projected to outstrip available capacity. On these occasions additional sessions were put in place or elective capacity was taken down.
- 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. In June 2015, there was one case in oral surgery where a patient who's elective operation had been cancelled on the day of admission for non-clinical reasons was not offered another date within 28 days, against the target of zero. This equated to 4.0% of the elective activity completed in the period.
- Staff told us there were issues with access and flow at Gate 40 which had been reconfigured from a day surgery unit to a ward admitting all elective surgical patients and some trauma cases. The expectation when the unit was built was that 40-50 patients would be going through it; however it had become the arrivals area, which was not the intention. On the day of inspection 62 patients of which 50 were day cases accessed the unit including 12 trauma cases. Patients were not admitted to a bed preoperatively in the day surgery unit. Trauma cases were assessed as to whether they required surgery and the majority could be local anaesthetics that did not require a bed post operatively but a chair.
- The layout and facilities on Gate 40 did not promote a positive patient experience. Due to the number of day cases and acute trauma admissions the waiting area accommodation was exceeded and patients were waiting in ward corridors and consented and marked for surgery in the ward manager's office..
- Staff told us that overnight stay patients on Gate 40 could not breach a 23 hour stay. The unit had 8 overnight beds which staff told us were regularly occupied with patients from other medical specialties for longer than 23 hours; this meant that the admission of day case and elective patients were delayed due to a lack of beds and impacted on patients waiting to be discharged to the ward from PACU. However, managers told us that medical patients were very rarely accommodated overnight.
- There were no staggered admission times for all day surgical lists. All patients were admitted at 7am. Staff said they were frustrated with this as ENT had introduced morning and afternoon lists which had been very successful but this had not been replicated as good practice in other surgical specialities.

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.
- 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 433 complaints related to surgery at Pinderfields 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.

Surgery

The culture in theatres and staff morale had improved since our last inspection; staff appeared to be more engaged and receptive to making improvements to the service.

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 although IT systems for example in theatres did not always provide the tools for staff to monitor all surgical outcomes. The trust was developing approaches to improve staff engagement across all clinical areas. There were some examples of innovative practice.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- The divisions integrated performance report was structured around the five Care Quality Commission (CQC) domains, safe, caring, responsive, effective and well-led. The purpose of the monthly report was to identify and assess the division's performance against the key measures of quality, safety and sustainability against national and local targets.
- Performance was reported using a scorecard; indicators were grouped into six domains based on finance and the five domains of quality identified by the CQC and Trust Development Authority. Each indicator was assigned a red, amber or green (RAG) status based on actual and forecast performance against pre-defined thresholds and reviewed on an exception basis where performance below the required standard was identified. If an indicator was rated as red in any given month or amber for two consecutive periods, a recovery plan was requested from the responsible officer for submission to the following Board meeting.
- The divisional risk register was reviewed and managed through departmental and speciality meetings and divisional governance meetings. Risks at division level were identified and captured. There was some alignment between the risks on the risk register and what staff said was on their worry list for example staffing levels and referral to treatment waiting times.
- There was monthly protected clinical governance half days, where no theatre or outpatient sessions were scheduled for these half-days so staff could attend.
- Staff told us the theatre IT system did not provide the tools to look at all surgery outcomes. Data was difficult to find and production of reports was time-consuming. Staff said that the system could not be upgraded unless a permanent administrator was in post.

Leadership of service

- Nursing staff spoke positively of each other and reported that working relationships were effective and supportive.
- However, there continued to be historical management–clinician divides that had not been resolved and tensions remained amongst certain surgical specialities.
- Theatre staff told us communication from managers was much better and that staff were involved in decisions about the service.
- Ward sisters attended senior nurse days with the director of nursing and had ward manager meetings each week. The matron for surgery was visible and approachable.
- Nurses on SAU commented on good teamwork and supportive ward managers. They said they were able to raise concerns and felt confident these would be acted on.

Culture within the service

- There continued to be issues relating to the cohesiveness of certain surgical specialities. We found that the team remained dysfunctional without local consensus. Although there was no evidence to suggest individual clinicians were not caring for their patients, clinical engagement was not effective across all members of the team particularly across the Pinderfields and Dewsbury site. The trust had undertaken investigations (both internal and external) and was in the middle of an assessment however at present it was difficult to see full resolution.
- A few staff said that the only time they heard from senior managers was when they had done something wrong; however other staff felt they were receiving management recognition for good work.
- Most staff in theatres said the culture had improved since the last inspection. They commented that the mood of morning theatre meetings were effective with more staff coming forward and asking questions and wanting to be involved. However, some staff felt morale could be better if there were more opportunities for career progression and flexible working.
- The trust had re-launched the MY Star awards and had also been revising the Celebrating Success event following feedback staff gave about changes they wanted to see. A surgical ward sister said she had been nominated for the team star of the month award which was presented by the CEO.
- Ward staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Most staff said they could approach the CEO and directors and raise any concerns. For example, staff had received support during a recent whistleblowing incident.
- The SAU team were proud of the work they had done over the last 12 months particularly in the reduction of staff vacancies and sickness absence rates.
- Ward meetings took place. Minutes from a meeting in June 2015 showed areas discussed included infections control, staffing, incidents, complaints, audits and operational ward issues.
- 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%.

Public and staff engagement

- 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.
- We saw examples of the ‘You said we did’ boards. For example, in response to patient feedback relating to a lack of communication and information, ward 33 was piloting a ward round where sisters introduced themselves to patients and discussed any concerns.

Innovation, improvement and sustainability

- Theatres had introduced a five minute morning meeting where staff received updates about the trust, good news stories and any issues. This had been positively received by staff.
- Staff on Gate 40 were working with the business delivery manager to look at processes to improve patient care which included staggered surgical admission times for patients, improved scheduling of theatre lists and nurse led discharge.

Maternity and gynaecology

Safe	Requires improvement
Well-led	Good
Overall	**Good**

Information about the service

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

Between April 2014 and March 2015 the total number of births at Pinderfields maternity unit was 3503 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. We found essential equipment checks, to ensure it was available in an emergency situation were not taking place, and the midwife establishment was below the national recommendation. Although there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service, there were mixed messages about how open the culture was within the leadership team; staff felt senior managers were not always visible. The overall rating for the service was requires improvement.

This inspection took place on the 23, 24 and 25 June 2015 and was part of an announced focused inspection to follow up the outstanding requirement from the previous inspection. We inspected the antenatal triage, (which opened 24hours a day,) delivery suite, and the antenatal and postnatal ward. We spoke with three women who used the service; received three CQC patient feedback forms, and spoke with 13 staff, including health care assistants, student midwives, midwives, doctors, consultant obstetricians and senior managers. We also observed care and treatment, inspected seven sets of post-natal care records and reviewed the trust's performance data.

We found 4.6% of the population in Wakefield belong to non-white ethnic minorities. The average proportion of Black, Asian and Minority Ethnic (BAME) residents in Wakefield (4.6%) was lower than England (14.6%). Of all 362 Local Authorities in England, Wakefield was ranked as the 67th most deprived.

Maternity and gynaecology

Summary of findings

Overall at this inspection we rated the service as good. We found in delivery suite, daily checks of essential equipment to ensure it was available in an emergency situation were not taking place. This information was also found at our previous inspection in July 2014. Although steps had been taken to try to address this in 2014 and in the week prior to our inspection, it was too early to show changes had taken 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, Bereavement midwife 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. The medical staff skill mix at the unit was in line with the England average, and the cover on labour ward was 98 hours a week. This was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance that there was 98 hours of consultant presence for a unit with 4000–5000 births.

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

Are maternity and gynaecology services safe?

Requires improvement

We rated the service as requires improvement for safe. We found in delivery suite, daily checks of essential equipment to ensure it was available in an emergency situation were not taking place. Although steps had been taken to try to address this the week prior to our inspection, it was too early to show any changes had taken 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, Bereavement midwife were not included in these figures. The medical staff skill mix at the unit was in line with the England average, and the cover on labour ward was 98 hours a week. This was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance that there was 98 hours of consultant presence for a unit with 4000–5000 births.

Incidents

- Between May 2014 and April 2015 there were two reported serious incidents across the trust in women's services compared to nine in 2013/14. We saw these related to an intrapartum stillbirth (the death of a baby during birth after 24 or more weeks of pregnancy,) and a failure to obtain consent for medical termination of pregnancy.
- A root cause analysis (RCA) had taken place in both cases which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important lessons are learnedto prevent the same incident occurring again. An action plan, recommendations and subsequent changes in practice were shared with all staff. This was by e-mail, face-to-face communication, in team meetings and via the trust 'Maternity Measured' newsletter, which we saw was displayed within each ward and unit (issues 4, June 2015).
- Additionally, we saw information which showed staff received updates regarding guidelines which had been introduced or changed to ensure staff were kept informed and patients received safe care. For example, updated guidelines for the use of Anti-D

immunoglobulin. (Anti-D(RHO) Immunoglobulin is used to prevent pregnant women who have a rhesus negative blood group from producing antibodies against their rhesus positive foetus.)

- Midwives and staff we spoke with told us they were encouraged to report incidents and were able to explain the procedure. They reported having received patient safety briefs; designed to rapidly disseminate learning from incidents or other concerns which had occurred within the trust.
- During our inspection on delivery suite, following the staff handover we saw a safety brief was given on the guideline of the week, 'Maternal obesity in pregnancy.' One of the objectives of the guideline was to make health care professionals aware of the risks associated with obesity; therefore help women to receive the appropriate level of care thereby reducing the risks to both mother and baby.
- We also saw a copy of a weekly email, sent to staff and dated, 30 April 2015, from the Head of Midwifery/ Supervisor of Midwives. It included information about serious incident and how there had been fewer than the previous year, it also mentioned how feedback to staff about the outcome of an incident they had reported, had improved.

Environment and equipment

- At our inspection in July 2014 we found in the delivery suite, daily checks of essential equipment, including resuscitation equipment had not always been completed.
- At this inspection we found between January and June 2015, there were several occasions when the adult resuscitation trolley equipment in the delivery suite, had not been checked. We saw one of the intravenous infusion fluids on the trolley had expired in April 2015; this was removed by a member of staff at the time of the inspection.
- We inspected two out of 13 paediatric resuscitaires, numbers three and seven. Records showed for the month of June 2015, resuscitaire number three had not been checked on five occasions and rescuscitaire number seven had not been checked on four occasions. This meant the equipment might not have been available for use in an emergency situation.
- We found on the postnatal ward the resuscitation equipment had been checked daily, for both adults and babies and were 100% compliant. This meant the equipment was available for use in an emergency situation.
- During this inspection the trust provided CQC with information that stated, following the inspection in July 2014 when non-compliance with resuscitaire checking had been identified, environmental audits were carried out by external auditors and included resuscitation checks.
- Matrons were reported to have found 100% compliance when checking the monthly audit tools however, when spot checks were carried out, this was not always the case. The information stated the system was then changed to department managers checking the resuscitaires and they had given verbal assurance to the matrons of compliance. Spot checks carried out by the matrons showed compliance was not 100%.
- We spoke with the Head of Midwifery and band 7 delivery suite co-ordinator. They confirmed two weeks prior to our inspection, steps to address the situation had been taken to try to ensure the daily checks take place. We also saw a copy of the 'Ward Managers (acute inpatients) Weekly Standard of Care Assurance Framework' dated 15 June 2015, which identified the action to be taken following the non- compliance. This included the recording of the named midwife responsible for checking the equipment each day. On the day of our inspection we found omissions in the checking and recording of the information remained. Although steps had been taken to try to address this the week prior to our inspection, it was too early to show any changes had taken place.

Consent

- We saw evidence consent was obtained in peoples' records prior to procedures taking place. For example, when having a caesarean section. Although we did not see records relating to obtaining consent prior to a medical termination of pregnancy following the reported serious incident, the RCA identified contributing factors, notable practice, learning and recommendations. The midwives spoken with were aware of these and we saw the information had been circulated to staff in the 'Maternity Measured' newsletter.

Midwifery staffing

- We found the birth to midwife ratio had increased from 1:33 to 1:31 since our inspection in July 2014. National guidance for the birth to midwife ratio was 1:28. However, the King's Fund report ("Staffing in Maternity Units -Getting the right people in the right place at the right time" 2011) suggested, that whilst staffing levels were important, employing more staff may not necessarily improve safety and maternity services had found it unrealistic to increase staff numbers to meet this ratio.
- The midwife to birth ratio of 1:31 was reflected in the trust dash board, and risk register and considered to be a low risk.
- A midwife told us not all women received 1:1 care in labour. However two women spoken with told us there were sufficient staff on the wards to meet their needs, they had received continuity of care and 1:1 support from a midwife during labour.
- The seven sets of records inspected showed staff used a 'fresh eyes approach' (Fitzpatrick and Holt, 2008) when monitoring foetal wellbeing through the use of cardiotocography (CTG). (A 'fresh eyes approach' (Fitzpatrick and Holt, 2008) can enhance the accuracy of CTG interpretation as the tracings are viewed by more than one person. Fitzpatrick and Holt (2008) found that two people operating together as a single unit were able to monitor and help each other, leading to a learning process essential for effective professional practice and can enhance the accuracy of CTG interpretation.)
- Specialist midwife roles for example the Bereavement, Teenage pregnancy, Antenatal screening, Substance misuse, and infant feeding midwives were not included in the 1:31 birth to midwife ratio.
- We saw the trust had a 'Maternity and Neonatal Services Escalation and closure Policy' Staff in each area we inspected, were aware of the staffing escalation protocol should staffing levels per shift fall below the agreed levels. They reported cross department/ site team working when needed to address shortfalls and the use of bank, and more recently agency staff.
- Staff reported they had recently started to use agency staff. At the time of inspection an agency member of staff were seen to have an orientation to the delivery suite by a member of permanent staff and this included the identification of fire exits. Documentation was not seen in use for the orientation. Therefore there was no record the induction orientation had taken place. Key areas could have been missed, and in the event of an emergency the staff member may not know the layout of the environment. Recruitment checks had been carried out and these included the midwives intention to practice.
- The Head of Midwifery (HOM) informed us of an extra layer of management which had been introduced. On delivery suite we met one of these staff; the ward manager. Staff reported how this had made a big improvement to the management and staffing in this area. They told us staffing had been unsettling over the last year, and they now felt optimistic with the improvements taking place. The HOM also acknowledged the band seven (manager) staff grade was currently reduced due to the impact of sickness and absence and an acting interim post had been created. With the reconfiguration of services the establishment was said to allow for two band sevens; this would provide extra time for these staff to keep their skills up to date.
- Senior staff told us core midwifery staff worked in each area, whilst other staff rotated between departments and this included the community midwives. One of the staff told us they felt there was some disparity between the staff rotations. They said there were not as many band six experienced midwives when compared to Dewsbury, and a number of the band six midwives were reported to have permanent night duty shifts. The trust has subsequently confirmed that there are no midwives on permanent night shifts.
- We saw the HOM had commenced a newsletter which she emailed out monthly to staff. The copy, dated 30 April 2014, referred to the rolling out of the rotation programme following a questionnaire asking where staff would prefer to work. This meant staff would have the knowledge and skills to be able to work in different areas and flexibly to meet the needs of patients on the maternity unit.
- The service used an acuity tool to assess workloads. The delivery suite coordinator told us they reported the staffing levels three times a day (and we saw this taking place in delivery suite at the time of inspection). High levels of activity together with staffing levels were determined and escalated in line with the trust's staffing and escalation protocol (, together with the standard required for Safer Childbirth guidance).
- We saw the 'Private meeting of the trust board executive summary,' dated March 2015. The information referred to an overall assurance that "Midwifery services are safe

and had good operational plans to maintain the commissioned ratio of midwife to birth." And "When shortfalls occurred – staffing numbers across in-patient areas were appropriately reported and risk assessed. These processes occur three times daily and are documented." The report also stated although the staffing position required monitoring, it was improving following successful recruitment.

Medical staffing

- The medical staff skill mix at the unit was in line with the England average, and the cover on the labour was 98 hours a week. This was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance in relation to the number of births at the unit.
- Staff reported the consultant obstetricians were available when needed and also reported antenatal patients were seen each day in line with current guidance. Patients told us they received consultant and medical care which met their needs.
- There was a nationally reported shortage of junior medical staff and the skill mix at the unit was in line with the England average.
- We saw the trust had a 'Maternity and Neonatal Services Escalation and closure Policy' and staff were aware of the procedures to follow.

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 Pinderfields would become a consultant led/midwife led unit. Staff told us they were kept up to date with information about what was happening within the trust. They said the culture was open, transparent and felt their concerns would be dealt with appropriately; this included whistleblowing.

Vision and strategy for this service

- The women's service had a strategy and vision for the future of service provision in Wakefield, Dewsbury and Pontefract. 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.

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 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 and there were positive working relationships between the multi-disciplinary teams and other agencies involved in the delivery of service.
- Staff told us the HOM was very supportive and accessible; we saw a monthly newsletter 'Current News' which was sent to staff, keeping them up to date with what was happening in the trust. For example, the first addition dated 30 April 2015 acknowledged and praised staff on how they were coping through difficult times. It congratulated staff on new appointments and informed them on how the rolling recruitment programme was maintaining the staffing ratio of 1:31. It acknowledged staff having completed training, and how a survey would be completed to ensure they had the opportunity to use their additional skills and interests. It also informed staff about the rotation programme, and how following a questionnaire asking staff where they would prefer to work, everyone would have the opportunity to work in different areas and remain upskilled. The

newsletter referred to the HOMs accessibility, stated they accessed their emails daily, and were happy to discuss any suggestions anyone had about improving the service.

Please include additional subheadings if needed.

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.

The children's ward, gate 46, provided 24 children's inpatient beds for medicine and surgery along with additional weekday beds for day surgery. Five of these beds were children's regional burn's unit beds located in a dedicated area within the cluster areas of gate 46. There was also an outpatient service that cared for children and young people. The neonatal and special care baby unit (SCBU) were located adjacent to the maternity unit and consisted of four neonatal intensive care cots, three high dependency cots, and eight special care cots.

During an inspection of Pinderfields Hospital in July 2014 we found the safe and responsive domains of required improvement.

In June 2015 we undertook a focused follow-up inspection in order to see whether improvements had been made. During this inspection we visited gate 46, including the burn's unit, and the neonatal and SCBU unit. We talked with 21 nursing staff, eight medical staff, and examined documentary evidence provided to us by the trust. We also spoke with eight children and young people, and their parents.

Summary of findings

We undertook a focused follow-up inspection in June 2015. This followed an earlier inspection in July 2014 where we found the safe and responsive domains required improvement.

At this inspection we rated safety as good, whilst we rated responsiveness as requires improvement.

At the July 2014 inspection in the safe domain we found that staff did not always receive feedback on incident reports, and there was confusion over version control on risk registers. We also found shortages of nursing staff in all the areas we visited.

At this inspection we found that staff did receive feedback on incident reports, and that there was clear version control on the risk register.

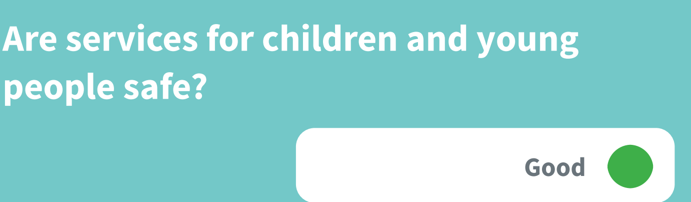
There were improvements to the levels of nurse staffing. The service had committed resources to bringing in additional members of staff. Although not all these staff were in place at the time of the inspection the trust were actively recruiting. Within children's services we found that safe staffing levels were maintained by staff working extra hours, and through the use of temporary agency staff. Therefore we found that the service still required improvement for safe.

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.

Services for children and young people

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 whose role 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 responsive.

Are services for children and young people safe?



At our inspection of the service in July 2014 we rated this domain as requires improvement. Staff told us they did not routinely receive feedback about incidents they had reported to the trust, and there was confusion over version control of risk registers. We also found shortages of nursing staff in all the areas we visited.

During our focused follow-up inspection in June 2015 we found that staff now routinely received feedback on incidents, and there was effective version control of the risk register.

There were improvements to the levels of nurse staffing. The service had committed resources to bringing in additional members of staff. Although not all these staff were in place at the time of the inspection the trust were actively recruiting. Within children's services we found that safe staffing levels were maintained by staff working extra hours, and through the use of temporary agency staff.

We therefore found that the service should be rated as requires improvement.

Incidents

- At our inspection in July 2014 staff told us they did not routinely receive feedback about incidents they had reported to the trust. This meant they were not always made aware of how the incident had been investigated and where learning from the incident had taken place.
- During our inspection in June 2015 staff told us they now routinely received feedback on incidents, including the results of any investigations and associated learning.
- Initial feedback to the person who had reported an incident on the electronic Datix system took the form of an acknowledgement email. Later they received further feedback on the results of any investigation, and associated learning.
- In cases appropriate to their area other staff would receive feedback through emails and at team meetings. Staff told us they were expected to attend at least half of all the team meetings that took place each year, and that the minutes were emailed to them.

- 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 managers 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

- At our inspection in July 2014 we found shortages of nursing staff.
- During our inspection in June 2015 we visited the children's ward, gate 46, which included the children's burns unit, and the day surgery unit.
- Gate 46 provided 24 children's inpatient beds for medicine and surgery along with additional weekday beds for day surgery. Five of these beds were children's regional burn's unit beds located in a dedicated area within the cluster areas of gate 46. Although the burns unit was part of the children's ward it was separately staffed.

There was also a bay used on week-days for day surgery, which was staffed by gate 46 staff.

- We found there was a band 7 nurse in-charge of the gate 46, the day surgery unit and the burns unit.
- On the two days of our visit we found that gate 46, including the day surgery unit, was staffed by six trained nurses and two healthcare assistants. Out of this number one trained nurse and one HCA were based in the day surgery unit. This was confirmed to us by staff and by a review of the ward's staffing rotas.
- The rotas also showed that on the weekends and nights, when the day surgery unit was closed, the staffing was reduced to four trained nurses, and two health care assistants.
- On the five bedded burns unit there were two trained staff and one HCA during the day, and two trained nurses on night
- Staff worked two 12 hour shifts, to cover both days and nights, with a half-hour handover period.
- These were the planned staffing levels for the ward 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.
- We spoke with both trained nursing staff and HCA's, who told us that the staffing situation had improved since our last inspection.
- Since our inspection in July 2014 the trust had appointed an HCA to work nights on gate 46 where previously an HCA had been shared with the burns unit. This now meant that there was an HCA present at all times to help cover the ward, including when trained staff on either of the two clusters that made up the ward were checking drugs.
- In addition to the band 7 lead nurse who was in overall charge of the children's ward, there was a band 6 nurse in charge of the day-to-day running of the ward, assisted by a band 5 ward coordinator. The head of children's nursing told us that the trust intended that the ward coordinator would become supernumerary, as recommended by the Royal College of Nursing (RCN) recommendations: "Defining staffing levels for children and young people's services; Second edition, August 2013 (RCN)". Although this was not in place at the time of our visit.
- There was also a bay used for high dependency patients. Although this was not always in use it was actively used during the winter months and whenever it was required by a child who required high dependency care. Although the general staffing levels were within the RCN recommendations there was no substantive cover for these high dependency beds.
- Senior managers and staff told us that they would flex their nursing establishment to cover these beds with agency and bank staff being brought in when required. Staff told us that if these additional staff did not have the appropriate qualifications or experience to care for high dependency children they would be placed in the general ward area, whilst a qualified member of the substantive nursing team looked after the high dependency patients.
- At our inspection in July 2014 we found that because there was only one trained children's nurse on the burns unit at night this meant they fell below the standard set out in the national burn care standards of 2013: "National Burn Care Standards; 2013 (National Network for Burn Care)".

- Since our visit in 2014 the trust had changed the staffing arrangements on the burns unit to ensure there was two trained staff on night duty.
- During our 2014 visit we also found that the two trained children's nurses on the burns unit managed burns' outpatient attendances as well as looking after children on the ward. Since our earlier inspection the trust had introduced an HCA during the day shift to assist the two trained nurses.
- Nursing staff we spoke with told us that these two extra trained nurse posts on the rota were covered by the current staff working extra hours.
- Senior managers within children's services had told us that 2.6 WTE had been funded by the trust to increase the level of staffing on the burns unit on a permanent basis. However, staff on the ward told us that this was not the case and that only 1.0 WTE had been agreed by the trust.
- Following this conversation with staff senior managers told us that the full 2.6 WTE increase had been agreed, and informed the burns unit staff this was the case. However, this was not reflected in staffing establishment figures for the unit for the week commencing 29 June 2015, sent to us by the trust. These figures showed a vacancy level of 0.58 WTE.
- We visited the neonatal unit that was located adjacent to the maternity unit and consisted of four neonatal intensive care unit (NICU) level 3 cots, three high dependency unit (HDU) level 2 cots, and eight special care baby unit (SCBU) level 1 cots. The British Association of Perinatal Medicine (BAPM) requirements are that there are: one trained nurse for one patient in the NICU, one trained nurse to two patients in the HDU, and one trained nurse to four patients in the SCBU. Two of these nurses, on each shift, should be Qualified in Speciality (QIS) neonatal nurses.
- During our inspection of July 2014 we found there was limited flexibility in the establishment to cover busy periods.
- Senior staff on the neonatal unit told us there were five trained nurses and two HCA's during the day, and five trained nurses and one HCA at night. Out of this number all the band 6 and 7 nurses were Qualified in Speciality (QIS), whilst five band 5's also had taken the QIS course. Out of the remaining trained nurse numbers five of the band 5's were waiting to complete the QIS course.
- We also reviewed the rotas covering the period 15 June 2015 - 5 July 2015. This showed that the service was not always able to have the above numbers of trained nurses and HCA's on duty at all times. This meant that the service was not always able to meet the BAPM requirements. However, there was always at least two QIS nurses on duty.
- Senior staff also told us they were short of staff and there were vacancies for two band 5 and two band 6 trained nurses. However, the staffing vacancy report for week commencing 29 June 2015 submitted to us by the trust reported that there were 1.31 WTE vacancies for the neonatal unit. The trust has stated that the vacancy report details vacant posts which can slightly differ from operational position if a vacancy has recently occurred.
- Senior managers and staff told us that there was a continuing review of staffing throughout the trust which would see all acutely sick children come to Pinderfields from the Dewsbury site. Staff told us they had already seen an increase in the number of sick children coming from the Dewsbury area.
- Patients and relatives we spoke with told us that they never felt they had to wait a long time before being seen by a nurse.
- 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.
- 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.
- 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.
- 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.

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 on the day surgery ward 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 always 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 whose role 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, whose role was to lead on transition services. However, we found 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 Pinderfields hospital. The specialist palliative care team (SPCT) had a clinical and educational role within the hospital. The team also provided a service to Dewsbury 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 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 several wards and looked at 20 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 25 staff including ward nurses, bereavement officers, mortuary staff, doctors, porters, the SPCT, discharge team and senior managers. We also spoke with a volunteer and two patients who were receiving care. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

We found end of life care services at Pinderfields hospital to require 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. There had been 777 referrals to the SPCT from April 2014 to March 2015. This was an average of 65 per month. We found senior leaders did not have full awareness or understanding of the challenges of the service.

The process for rapid discharge of patients at the end of life was protracted and lengthy. We observed examples where discharge had been unnecessarily delayed .Not all ward staff had been trained to use or were using the end of life care plan.

There had been some improvement in documentation around involvement of patients and relatives with ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions. We found a small number of records where the mental capacity act and trust policy had not been followed.

End of life care

Are end of life care services safe?

Inadequate

We found that both nurse and medical staffing levels in the specialist palliative care team were of concern, this had been reflected within the risk register. The clinical governance review of February 2015 indicated there were five whole time equivalent (WTE) vacancies within the SPCT. There were 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, however 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.

There had been improvement with compliance of the 'do not attempt cardio pulmonary resuscitation' policy (DNACPR); however there were instances where capacity assessments had not been completed and one patient had not been involved in decision making because he had hearing loss.

There were processes in place to ensure action was taken as a result of incidents or when things went wrong. We found good adherence to infection prevention and control and environmental checks in the mortuary.

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.

Incidents

- 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 regulation would be used if something had gone wrong.
- Duty of candour 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.

Cleanliness, infection control and hygiene

- We were shown a cleaning checklist of the mortuary from March to June 2015; this showed 100% compliance with cleaning and infection prevention and control (IPC) checks.
- The mortuary trolleys were cleaned after every use according to best practice and trust policy.
- Deceased patients were checked every day to ensure no leakage of bodily fluids had occurred.

- Head blocks were in use on the mortuary trolleys in line with trust policy. (Head blocks are commonly used in order to prevent any stomach contents moving to the patient's mouth).
- We observed clear infection prevention and control labelling which would help protect staff from infection.
- Personal protective equipment (PPE) was readily available and staff were able to tell us how this should be used.

Environment and equipment

- The mortuary was a store for both deceased hospital patients and those who had died in the community. It was also an area where post mortem examinations took place.
- We saw the mortuary area was secure and fridges were locked.
- We were shown fridge temperature audits from May 2015, there was full compliance with these.
- We also saw environmental audit results from December 2014. These audits took place every two months by senior staff. The audits we saw showed 100% compliance.
- We saw there had been monthly audits of non-viable foetus' remains to ensure correct procedures were being followed. The results showed this to be the case.
- There was standardised use of McKinley syringe drivers on the wards and these were available from medical physics.
- We were told of side rooms on wards (called 'gates' at Pinderfields) 42, 43 and 44 which were being adapted into more therapeutic areas for patients at the end of life. They were due to be officially 'opened' in the middle of August 2015.
- There was only one concealment trolley for the hospital. One porter told us it needed repair or replacement as it had been "defective" for five years.

Medicines

- 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 is 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 not be able to prescribe until September 2015.
- 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 varying levels of completion of documentation; for example on gate 33, and end of life care plan had a patients preferred name clearly documented and the preferred place of care, however the section of 'relationships with significant others' was left blank even though the patient was married.
- The bereavement office kept records of all hospital deaths and funerals which had been arranged by the hospital when there was no next of kin or no means for families to arrange a funeral.
- Chaplaincy staff told us they documented in the end of life care plans when they had spoken with patients or their families.
- We were told electronic record system (known as Q pulse) was where audit results and other information were kept.
- There was clear identification in different coloured writing on mortuary fridge doors to signify if the deceased had been a hospital patient or had died in the community.

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.

Nursing staffing

- We found that nurse staffing levels in the SPCT were a concern; this had been reflected within the risk register. The clinical governance review of February 2015 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 of 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.
- 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 of a concern. 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 one whole time equivalent registrar post was also reduced from one 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 were 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 were 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 and the weeks had been split.

End of life care

Other staffing

- We were told the mortuary was staffed by three technicians, a 0.6 whole time equivalent (WTE) trainee and two further mortuary assistants. They were line managed by a pathology manager who was responsible for microbiology, pathology, the mortuary and 'point of care' testing facilities. (Point of care testing meant patients could have investigations such as blood tests and have medication doses adjusted at the same time rather than coming back to hospital).

Major incident awareness and training

- There were contingency plans to be used in the event of a major incident or space becoming unavailable in the mortuary. Staff told us there was an agreement with neighbouring trusts to utilise other mortuary areas in these situations. The procedure was clearly document in the policy 'contingency plans for mortuary overflow'. Staff we spoke with were aware of their roles in such an event.

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 plan used at Pinderfields demonstrated the team had referred to national standards to ensure patients were appropriately assessed and supported. The SPCT are members of the Yorkshire cancer network, 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.

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Evidence-based care and treatment

- The end of life care plan used at Pinderfields 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 meeting with local GP's to support quality care and prevent unnecessary hospital admission.

- 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 '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 cancer network, 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, 100% of patients said they had enough time to talk and their privacy and dignity was respected; Overall feedback of the service found 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, 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.
- Staff on ward four told us they hadn't received training so weren't using the care plan. It was not clear what care plan these areas were using for patients at the end of life.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) audit

- 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 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. .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.
- 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 12 'do not attempt cardiopulmonary resuscitation' (DNACPR) records. Most were filed properly at the front of medical notes; one was filed in nursing notes on gate A2, one was behind several other sheets. There were two forms which stated the patient did not have capacity, but no capacity assessment had been carried out.
- Two other forms indicated those patient had had a capacity assessment, but we could not find evidence of this in nursing or medical records.
- One record from the acute assessment unit indicated there had not been a discussion with the patient; the reason for DNACPR was "multiple co-morbidities", there was no mention of capacity in the medical or nursing records.
- On gate A1, one DNACPR form stated no discussion had been had with the patient as they were "very deaf"; there was no mention of capacity, it had been discussed with a relative, and we did not find this an appropriate reason not to discuss with a patient. We checked the records, there was no evidence discussion had taken place with the patient.
- The Resuscitation Council guidelines (2015) recommend "effective communication with and explanation of decisions about CPR to the patient, or clear documentation of reasons why that was impossible or inappropriate". The trusts DNACPR policy incudes "There need to be convincing reasons not to involve the patient."
- On gate 32a, one record showed the reason for DNACPR was "dementia"; notes indicted a need to discuss with family. We could not find evidence of any such discussion, nor could the ward sister. A capacity assessment had not been carried out for this patient. The trust policy states "this is good practice and is required by the Mental Capacity Act 2005 "
- On the acute assessment unit (AAU) we saw records which stated the reason for DNACPR as "Multiple co-morbidities", there was no further explanation, there had been no discussion with the patients, and there was no mention of capacity.
- Following the last inspection, the trust had been advised it must "ensure the procedures for documenting involvement of patients and relatives in 'DNACPR' are in accordance with best practice at all times". We found this was still not the case in the above circumstances.
- We saw good practice on gate 20; a patient with capacity was aware of the DNACPR status, the reasons for which were clearly documented, and did not want this communicating to his family, we found his wishes had been respected.

Pain relief

- We visited gate A3 and spoke with registered nurses who told us they had all been trained in the use of McKinley syringe drivers used for continuous pain relief, and they felt confident in their use.
- We spoke with a patient who told us they had been kept comfortable and pain relief was available when they needed it.
- 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

- One nurse on gate A2 told us there could be delays in obtaining syringe drivers from medical physics. In the event of this happening they would borrow one from another ward if they had finished using it.

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.

Competent staff

- 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.
- Seven staff received training on ‘end of life care after a stroke’ during March 2015. The trust told us this was part of a rolling programme of training on the stroke ward. A number of other staff attended a one day end of life conference in April 2015.
- We found 70% of the SPCT had received an appraisal in the preceding year.
- The SPCT showed us a programme from March to November 2015 for end of life care training. We were told the training is often cancelled as general nurses find 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.
- The ward nurses do not act as ‘link’ nurses 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
- Two of the SPCT nurses have master’s level qualifications.
- Staff from the bereavement team spend one day a year shadowing the coroner and also the registrar (of births deaths and marriages) in order to keep up to date with procedures.
- The bereavement team also told us they provide some training for nurses and medical staff in order that clinicians better understand the role of the bereavement team.

- Mortuary staff told us they were accredited by the human tissue authority (HTA) and are also have clinical pathology accreditation (CPA). The CPA was renewed in 2014 and is checked every four years for compliance with standards. The most recent visit by the HTA was January 2014. The mortuary had to comply with health and safety executive (HSE) standards and had been checked by them, but staff could not recall when the HSE visit had occurred.
- Staff in the mortuary were trained in moving and handling deceased patients as were two porters we spoke with.
- One porter told us there was no opportunity to discuss or reflect on dealing with deceased patients, this could be difficult for some staff. The porters did not have a base where they could share experiences.
- We spoke with nurses on gate A2, they told us 50% of ward staff had received training on use of the end of life care plan; those staff were due to cascade the training to other staff.
- Nurses on gates A2 and 34 told us the SPCT were very responsive and supportive.

Multidisciplinary working

- We found good MDT working between SPCT and other specialities.
- The bereavement team and 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.
- We were told the SPCT would like to be able to participate in ward rounds in order to share good practice and decision making in uncertain progressive situations and to help the flow of patients through hospital, but they were not staffed adequately to be able to do this. . The Royal College of Physicians (RCP 2013) recommends joint working between palliative care staff and services such as heart failure, respiratory, renal and neurological medicine. Following our inspection, senior managers told us the SPCT participated in the fortnightly heart failure MDT, the motor neurone disease clinic and monthly, and met frequently with the lung cancer nurses.
- One nurse on gate A2 told us there was a multidisciplinary approach to deciding when a patient was nearing the end of life. Doctors respected nurses' opinions about the commencement of the end of life care plan.
- 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 systemallows for speedy communication and joint working between hospital and community teams.
- Chaplaincy staff were consulted on the development of therapeutic side rooms for gates, 42, 43, and 44.
- The hospital has a contract relationship with a named funeral director who made funeral arrangements when a patient died without any means to pay for a funeral and with no family or friends who were able to do this on their behalf.

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.
- 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.

End of life care

- The chaplaincy team told us they provide 24 hour on call cover despite having just three WTE staff.

Access to information

- When the SPCT visited a patient they gave them a green card with contact details on, this card also had an out of hour's number for GP's in case the patient and family need this service after discharge.
- None of the leaflets or cards we saw were 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.
- We were shown a chaplaincy information leaflet 'the multi faith chaplaincy- spiritual and religious care for all'
- There were information sheets to help families participate in care for example 'how to carry out mouth care'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw good practice in care records for a patient with learning disabilities who had who had been considered to be nearing the end of life, and had recovered. A mental capacity assessment had been completed appropriately and deprivation of liberty safeguards (DOLS) was in place. The DOLS authorisation forms were appropriately completed.

Are end of life care services responsive?

Requires improvement

Overall we rated end of life care as requires improvement for being responsive.

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 have left hospital.

Relatives were actively discouraged from viewing deceased patients outside of working hours. We found this did not take the needs of bereaved families 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 777 referrals from Pinderfields hospital to the SPCT from April 2014 to March 2015; this was an average of 65 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%).

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).

Chaplaincy volunteers at Pinderfields carried out pastoral care such as listening to and supporting patients and their families in end of life situations.

On gate A2 we observed a 'you said, we did' board; it indicated the ward team had brought camp beds into use for families who stayed overnight with patients to make their stay more comfortable. We found evidence of learning from complaint and concerns.

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 777 referrals from Pinderfields hospital to the SPCT from April 2014 to March 2015; this was an average of 65 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%).

- 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).
- Only one team member was a nurse prescriber; another nurse specialist studying for this would not be able to prescribe until September 2015. This put pressure on the one nurse prescriber and did not ensure a fully responsive approach to patient need.
- 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

- There were plans to create therapeutic side rooms for patients at the end of life on wards 42, 43 and 44. Work was due to begin in July.
- 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 used the relative's page in the end of life care plan to respond to specific concerns when they are supporting families.
- There were eight chaplaincy volunteers at Pinderfields, 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.
- There was an organ donation programme at Pinderfields. We were told only corneal donations took place.
- On gate A2 we observed a 'you said, we did' board; which indicated the ward team had brought camp beds into use for families who stayed overnight with patients to make their stay more comfortable. The same ward nurses told us they had seven side rooms which could be used for patients at the end of life
- We observed a section in the end of life care plan where patients and families could be asked about a preference for clothing after death.
- We spoke with two porters; they told us "it is important to still see deceased patients as people"; one of the porters told us he talked to the deceased patients as he would if they were alive, he found this helped him to respect their dignity.
- We found that families or carers of patients with dementia who were nearing the end of life were given a discounted meals and drinks in the dining room. They were given a password on the ward.
- We were given a comment card at Pinderfields which read "excellent oncology and palliative care at Pinderfields".
- Bereaved families were actively dissuaded from visiting their loved ones outside of working hours. 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.

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.
- There had been 777 referrals from Pinderfields hospital to the SPCT from April 2014 to March 2015; this was an average of 65 patients per month.
- In April and May 2015, 96% of patients referred to the SPCT were seen within two working days of referral. This was achieved despite a lack of nurses in the team.
- 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 was sent to the Clinical Commissioning Group (CCG) so a funding decision can be made. We found no one took 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 Pinderfields 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 placedon 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.
- We found unnecessary delays and a lack of discharge planning for an end of life patient on gate 41. Records indicated the decision had been made on 11th June to discharge the patient back to their care home for end of life care. Despite intervention from several professionals and written queries as to why the patient was not discharged, no one appeared to have taken responsibility for the discharge plans for 13 days. We spoke with the ward sister who told us a Fast Track tool had been completed on 22nd June, that the patient then required a 'health needs assessment', but the decision had been made that day (24th June) not to discharge the patient as they were now too poorly for the journey in the ambulance. The patient had no family, and no one to advocate for them.
- The same patient had not received an assessment of their nursing needs since they had been admitted to hospital. We asked the ward sister how care could be planned without an assessment first; the patient had been in hospital over two weeks. The ward sister was unable to provide a reason for the lack of nursing assessment. A nurse on gate A2 told us three Fast Track patients had had a funding decision turned down by the CCG in the last year because the assessment was unsuitable; this affected the patient's length of stay. A nurse on gate 34 told us the current Fast Track process was unclear and this resulted in delayed discharges. Neither nurse was able to confirm exactly when this had happened.
- We met with the interim head of discharge planning. They told us the discharge team were soon to start a new way of working in order to speed up discharges for patients at the end of life. These plans included discharge liaison nurses undertaking the nursing needs assessment; they had received training to do this to a level the CCG required. The discharge nurse would also order necessary equipment once it had been requested by a therapist. The plan was for specialised equipment such as hospital beds, pressure relieving mattresses and oxygen (if required) to be delivered within three to four hours.
- 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 can affect the safety and speed of discharge from hospital.
- When the SPCT have use of the electronic palliative care coordinated system (EPaCCS) this could 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.
- We spoke with the ward based discharge liaison nurse on gate 20; a patient flow meeting was held on a daily basis Monday to Friday where discharge planning was the main focus.

Learning from complaints and concerns

- There had been four specific complaints relating to end of life care at Pinderfields from October 2014 to June 2015. One was around medication issues and the perceived attitude of a member of the SPCT. Appropriate action was taken and the complaint was

resolved. The second complaint was around patient care and the actions of a doctor. Appropriate action took place and the complaint was discussed at a team meeting so that learning from the complaint could occur. The third and fourth complaints related to the end of life care for the same person during the same care episode and were still under investigation.

- 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.
- 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.
- 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 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. 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 by staff that 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 "firefighting" 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, and had been discussed at a clinical governance meeting in February 2015. There had been a plan to recruit but this had been unsuccessful. There had been no other action to mitigate against this and 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.
- 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 were discussed on alternate months; the other month was a business meeting.

Leadership of service

- 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.
- Chaplaincy staff told us they had “fantastic support” of the senior manager, this helped to keep their roles at the forefront of services.

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 “firefighting” 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.
- Staff told us leaders could better understand the value of staff raising concerns and participating in decisions about the palliative care service.
- We found some evidence of the involvement of the end of life care facilitator in the work programme of 2015-2017.

Innovation, improvement and sustainability

- The SPCT are participating in a pilot for a new way of how palliative care will be funded. This has been agreed with the CCG and will mean any domiciliary visits carried out by the consultants will be paid for per visit rather than by block contract. It was not clear how this arrangement would affect the sustainability of the hospital palliative care service.
- 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

Outpatients and diagnostic imaging

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 there were no patient alarms in the cubicles allocated for the GP chest x-ray patients. The lead radiographer said this was on the basis that there was always someone around. All other cubicles had appropriate patient alarms, all reached the floor and were tested
- We found in radiology the resuscitation trollies were checked daily and all records were up to date. The service had adopted a system of a laminated A4 sheet with the day it was last checked. On inspection, there was a sign stating, ‘Resus Trolley Checked. TUESDAY’ Drugs and other medical supplies were checked and in 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
- We found daily quality control tests were carried out on all of the equipment we saw evidence of these in all rooms inspected including CT.

Medicine management.

- Within radiology we saw there were drug cupboards in each of the interventional rooms and a central store cupboard in the clean utility room. We found the room and cupboard was appropriately locked and secure.
- We saw the department undertook monthly audits to check stock against the records with pharmacy undertaking quarterly audits.
- We found there were no controlled drugs in the cabinet in the clean utility room, controlled drugs were stored in the interventional rooms and these were appropriately checked.
- Within the outpatients department at Pinderfields 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.

- At Pinderfields there was a “lead of the day” this person co-ordinated for the day and as a result this meant there was less interruptions in the scanning room.

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

Patient outcomes

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

Competent staff

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

Seven-day services

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff within outpatient's and diagnostics departments reported they had received training on mental capacity. Data showed that 64%-100% of staff had completed training specific for their role which included mental capacity training levels two and three.

Outpatients and diagnostic imaging

- 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

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

- 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 three 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.
- One patient we spoke with in the x-ray department told us they had been referred by their GP for a chest x-ray and they had received and had attended an appointment within 24 hours.
- At Pinderfields the CT and MRI scanning department the service was meeting the two week targets for scans this used to be four to five weeks. This was done through changing shift patterns and using locum staff. One member of staff told us they thought "the service was now fantastic as they were seeing patients until 8pm and were no longer turning patients away."

Meeting people's individual needs

- Staff told us within outpatients vulnerable inpatient cards (VIP) were used, they held information about patients, which helped staff when patients sought medical help. The VIP 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.

Outpatients and diagnostic imaging

- 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.
- 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.

Are outpatient and diagnostic imaging services well-led?

Good

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

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

Vision of the service.

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

Governance, risk management and quality measurement

- The management team told us there had been a complete turnaround of the service which had included the standardisation of processes, following up of the backlog of outpatients, compliance with performance targets which included RTT and a restructuring across the other services.
- The senior management team reported the improvements had removed the backlog of appointments, improved communication with staff and rewarded staff for their hard-work in making the improvements.
- Staff told us there was an action plan for the improvements needed within outpatients and there had

been a positive turnaround. Staff told us the action plan identified what was needed to be done on a daily basis and staff was accountable to make sure these were completed. One member of staff told us the action plan had focussed staff on what needed to be done and “it was excellent”.

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

Leadership of service

- Staff within outpatients told us that since the last inspection in July 2014 they now had a secure management structure and staff were very positive about the changes the management team had brought to the service.
- One member of staff told us “(the manager’s name) is the best manager I have ever had and I’ve worked in the NHS for 20 years.”
- Staff told us following the concerns within outpatients which started in the “winter of 2013” the Chief Executive of the trust had got involved with the work to improve the service and this had changed the focus. The Chief Executive chaired a fortnightly meeting about the service which monitored the outpatient improvement plan.
- Staff reported they had felt valued by their managers and executives in the trust as they had received recognition and congratulations for the turnaround they had achieved.
- Staff also reported they were proud of the outpatient service as they had all worked together as a team to secure improvements.
- Across the outpatient service listening into action (LIA) events had been held these were called the “big conversation”. LIA is a programme which supports staff to transform their services by removing barriers that get in the way of providing the best care to patients and their families.
- To support the development of the outpatient service staff across sites told us they had been involved with the improvements, they had had the opportunity to make suggestions and additional permanent staff had been recruited to support the work that needed to be done.
- Some staff told us they had used the “ask Chief Executive blog” where questions could be asked of the chief Executive. One person told us they were surprised but welcomed that the Chief Executive answered the questions himself.

- Staff told us a new Matron had been appointed but had not started yet to cover the outpatient department and they had not had a matron for a number of years. One member of staff told us “they felt reassured they would have a matron who would act as an advocate for nurses with senior management.”
- Within radiology staff spoke positively of the management. One member of staff said ‘it’s a very supportive team. We found team leaders worked well across all three sites.

Culture of the service.

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

Public Engagement

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

- 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.
- The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.

Outstanding practice and areas for improvement

- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users and to meet their needs.
- 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 robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

Action the hospital SHOULD take to improve

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- 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.
- The trust should ensure in community inpatient services there is a referral criteria for the service and in-reach assessments are carried out consistently to improve the admission and referral process.
- The trust should ensure toilet facilities in community inpatient services are designated same sex, in order to comply with the government's requirement of Dignity in Care.
- The trust should ensure care and treatment of service users is only provided with the consent of the relevant person.
- The trust should ensure patients receive person-centred care and are treated with dignity and respect.
- The trust should ensure the equipment and premises are suitable for the purpose for which they are being used and are appropriately maintained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

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

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 Meeting nutritional and hydration needs (2 a) (4 a, b, c, d). The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are met.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance (2 a, b, f) (3 b) The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients. The trust must ensure where actions are implemented to reduce risks these are monitored and sustained. The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board. The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed. The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing (1) (2 a) Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.

This section is primarily information for the provider

Requirement notices

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

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