

# The Mid Yorkshire Hospitals NHS Trust

## Quality Report

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

## Ratings

### Overall rating for this trust

Requires improvement 

Are services at this trust safe?

Inadequate 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Requires improvement 

Are services at this trust well-led?

Requires improvement 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

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

The acute services are provided in three hospitals, Pinderfields Hospital, Dewsbury and District Hospital and Pontefract Hospital. Pinderfields Hospital is situated in Wakefield and has approximately 639 beds. Dewsbury District Hospital is situated in Dewsbury and has approximately 358 beds. Pontefract Hospital is situated in Pontefract and has approximately 50 inpatient beds.

Community health services are provided across Wakefield District from a number of locations. The services are designed to mirror the seven GP networks in the district. This trust does not provide community services to the Kirklees area.

There were on-going plans for the reconfiguration of hospital services within North Kirklees and Wakefield, with a central hub for children's services; consultant led maternity services and acute emergency services located at Pinderfields General Hospital and a more local, elective service at Dewsbury and District Hospital and Pontefract Hospital. This had caused a level of anxiety amongst both the local population and the staff working at the trust. This new clinical strategy was subject to consultation.

The trust had been on the verge of administration up to two years earlier with a large underlying financial deficit, which had a significant impact on the provision of services. There had been changes at executive level over the last two years. The Chair and Chief Executive had originally been bought in to oversee an improvement and recovery programme, as the trust had been on the verge of administration. Changes had led to a leaner senior management structure. The director of finance has developed a financial plan supported by robust quality impact assessments and was confident that the financial gains made over the recent months could be sustained and improved upon.

Changes within management had been implemented at all levels of the organisation, which led to a feeling of instability in some areas. This manifested itself in low staff morale, demonstrated in poor staff survey results. Some areas expressed optimism for the future.

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

We inspected the following core services:

- Acute services: At Pinderfields Hospital and Dewsbury and District Hospital – accident and emergency, medical care (including older people's care), surgery, critical care, services for children and young people, end of life care and outpatients. At Pontefract Hospital – accident and emergency, medical care (including older people's care), surgery, maternity and outpatients.
- Community health services – children, young people and families, community adult in-patient services, end of life services and community adult services.
- Community dental services

Our key findings were as follows:

The trust was rated as requires improvement overall. Safety was rated inadequate, effectiveness required improvement, caring was rated as good, responsiveness required improvement and being well led required improvement.

During the inspection, we had significant concerns about staff shortages and risk to patient safety on Gate 20 (a medical ward) at Pinderfields Hospital. We immediately drew this to the attention of the trust, which took action in the form of closing 6 beds on the ward to bring the ratio of nursing staff to patients to acceptable levels of 1:8. We observed this had been maintained at our unannounced visit on the 27 July 2014. However, following our unannounced inspection, we received concerning information that there were still issues over staffing on this ward. As a result, we required the trust to provide daily information on patient and staff numbers and assurance over actions taken when staffing numbers

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fell below expected levels. Daily escalation mechanisms were put in place with a dedicated matron to lead on this. We continued to require daily updates from the trust regarding Gate 20 and have now handed the oversight of this to the NHS Trust Development Authority, who have been supporting the trust.

The trust put in actions to address concerns over Gate 20 and other concerns raised within this report and presented these at the Quality Summit on 13 October 2014. At the summit the trust gave assurance that they had taken immediate action to address serious concerns including the application of the Safer Nursing Tool, benchmarking practice over staffing with other trusts, appointing a Mental Capacity Act 2005 advisor, improved training and additional auditing systems.

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

In addition to the above we found:

For the acute services,

- We found the staff caring for patients were compassionate and treated people with dignity and respect. However, due to the significant staff shortages and movement of staff between areas, there was a level of frustration as staff were aware that they were not providing the quality service they aspired to provide. Staff morale was generally low across the acute services within the trust.
- New arrangements in governance and the management of risk had recently been introduced, but had yet to be embedded. It was too early to assess whether these new initiatives would deliver sustainable improvements.
- The reporting and standard of information relating to the level of risk to patients to the Trust Board was not always timely or robust.
- There was no evidence of risk for in-hospital mortality using the hospital standardised mortality ratio indicators or the summary hospital-level mortality indicator.
- Areas we visited were visibly clean. Infection rates for *Clostridium difficile* and Methicillin-Sensitive *Staphylococcus Aureus* were better than expected levels. Methicillin-Resistant *Staphylococcus Aureus* rates were worse than the expected levels.
- Staffing levels and skill mix were identified as a significant concern across a number of services and locations.
- The plans for the reconfiguration of children's services lacked clarity regarding the number of bed changes and how to staff these changes.
- There were no policies and processes to facilitate the development of adolescent transition services for those who needed to move to adult services.
- There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for assessment and treatment. There had been a validation process in place, which had reduced the numbers waiting, but this had not addressed the risks to patients whose condition may be deteriorating.
- We had serious concerns about the number of patients waiting to be admitted for treatment (the target for the referral to treatment at 18 weeks was not being met).
- The appropriate arrangements were not always in place for dealing with the storage, handling, administration and recording of medication.
- Equipment replacement and maintenance systems were not always effective. We had particular concerns over the analysing equipment within the pathology services.
- The trust was performing worse than the England average for a number of national audits, including the Myocardial Ischemia (heart attack) National Audit Project and the National Diabetes Inpatient Audit.
- The trust was performing worse than the average for the development of pressure sores and catheter-acquired infections.
- There were inconsistencies in record keeping including decisions over whether to attempt cardio-pulmonary resuscitation.

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- We had serious concerns about the way Mental Capacity Act 2005 assessments were undertaken and the lack of staff awareness and knowledge of the Mental Capacity Act 2005.
- Generally the trust was meeting the 95% target for patients being treated within four hours in A&E however there were some occasions when they didn't meet this.
- The trust had identified that the time patients were waiting in A&E to be handed over from the ambulance staff was a concern.
- The trust had medical patients, often 20 to 30 a day, on surgical wards, which meant there was a risk that they may be cared for by staff who may not have been trained in the appropriate medical speciality.
- There was a large backlog of typing for clinical notes and delays in discharge letters to GPs.
- The trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients.
- There were high numbers of complaints regarding outpatients going back many months, reporting distress and frustration at delays in accessing appointments, multiple cancellations of appointments, changes in location of appointments and the poor communication with the services.

In addition, for the community services,

- Patients were treated with compassion, dignity and respect across all the services.
- There were sufficient numbers of suitably trained staff to meet the needs of patients in most areas; however we had concerns that the staffing levels within the intermediate inpatient units were consistently below agreed staffing levels and patients were having to wait to have their needs met.
- Where there had been incidents reported, these had been investigated, practice changed and information disseminated to staff.
- Staff adhered to local policies and procedures and followed national guidance.
- Audits were undertaken and outcomes for patients were monitored. We saw that the majority of audits were positive and that action plans had been identified in areas where results were less positive.
- There was good multidisciplinary working in most of the areas we inspected.

- Staff were responsive to the needs of patients and able to meet targets such as community therapists visiting patients within 30 minutes of an urgent referral.
- Routine community services' performance information was identified by senior managers as an area of development.
- Staff were positive about local leadership of services. However, there were interim arrangements, particularly in the community inpatient services and staff were concerned about the sustainability of improvements.
- A few community services teams felt integrated with the rest of the trust. However, some felt they were not part of the wider trust.

We saw several areas of outstanding practice including:

- The development and provision of an integrated, multidisciplinary community health and care services for adults with complex needs. The team was newly created and had already seen over 400 patients. The team was made up of community matrons and nursing staff, therapists, dedicated social workers a full time pharmacist and the independent/charity sector. This meant the team was able to address patients' needs from assistance with shopping through to social care packages and intensive therapy, pharmacy and nursing input.
- Health visiting teams had implemented a link health visitor role to liaise about safeguarding with GPs, to work closely with GP practices to promote effective communication and share good practice.
- Staff within the children's community end of life care team (Jigsaw) demonstrated outstanding compassion and commitment. They helped parents and families create physical memories of their child such as a plaster cast of their child's hand so they continued to have a hand to hold.
- The urology department had been recognised nationally for the use of green light laser surgery, which is a minimally invasive procedure for prostate symptoms. The procedure enabled patients to return home within a few hours and return to normal activities within days.
- Patients discharged from the critical care unit were invited to attend a monthly outpatient clinic run by staff from the critical care service. Patients could be referred from the clinic for psychological support if this was needed.

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- The children's hospital-based service had developed a 'patient group directions competency assessment' support package for the nursing team. The package ensured the nurse had read and understood patient group directions before testing their knowledge and understanding.

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

Importantly, the trust must:

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

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- Ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Review the arrangements over the oversight of Gate 20 acute respiratory care unit to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013).
- Ensure the recommendations from the mortuary review are implemented and monitored to ensure compliance.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.
- Ensure actions are taken to address the poor decorative state of the mortuary to ensure effective and thorough cleaning can be undertaken at Dewsbury and District Hospital.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Mid Yorkshire Hospitals NHS Trust

Mid Yorkshire Hospitals NHS Trust is an integrated trust, which provides acute and community health services. The trust came into existence on 1 April 2002 when Pinderfields and Pontefract Hospitals NHS Trust merged with the Dewsbury Healthcare NHS Trust. The trust serves two local populations; Wakefield which has around 325,837 people and Kirklees with around 422,458 people. The trust employs around 8,060 members of staff, including 755 medical & dental staff.

The acute services are provided in three hospitals and have a total of 1047 beds. The hospitals are Pinderfields Hospital, Dewsbury and District Hospital and Pontefract Hospital. Pinderfields Hospital is situated in Wakefield and serves a population of 325,837 with approximately 639 beds (please note wards at Pinderfields hospital are referred to as Gates). Dewsbury District Hospital is situated in Dewsbury and serves a population of 422,458 with approximately 358 beds. Pontefract Hospital is situated in Pontefract and serves a population of 325,837 people in the local Wakefield and Pontefract area. The hospital has approximately 50 inpatient beds.

In 2010, the trust started providing community therapy services and intermediate care services. These services provided short-term specialist care to people who have been discharged from hospital but needed extra support, care and rehabilitation before they went home. In April 2011, as part of the programme of transforming community services, the trust took over the provision of community health services for the Wakefield district to include adult community nursing and children's and families' health.

Community health services are provided by the trust from a number of locations across Wakefield District. Services include health visiting and school nursing, an integrated care team that provided a 24-hour service, a new 'Proof of Concept' team as well as more traditional district nursing services and community matrons. Therapy services are provided in either a clinic setting or in patients' own homes as part of an integrated service. Some specialist services such as the tissue viability team are based in the acute hospitals but visit patients in the community. The services are designed to mirror the seven GP networks in the district.

The trust has annual revenue of £461m.

We inspected the following core services:

- Acute services: At Pinderfields Hospital and Dewsbury and District Hospital – accident and emergency, medical care (including older people's care), surgery, critical care, services for children and young people, end of life care and outpatients. At Pontefract Hospital – accident and emergency, medical care (including older people's care), surgery, maternity and outpatients.
- Community health services – children, young people and families, community adult in-patient services, end of life services and community adult services.
- Community dental services

We inspected this trust as part of our in-depth hospital inspection programme. We chose this trust because it was considered a high risk service.

## Our inspection team

Our inspection team was led by:

**Chair:** Mr Bill Cunliffe Retired Consultant Colorectal Surgeon

**Team Leader:** Julie Walton Head of Hospital Inspection, Care Quality Commission

A team of 60 people divided into two sub teams in order to inspect acute services and community services provided by the trust. The community service inspection included intermediate care and dental services provided by the trust.

The acute team comprised of Care Quality Commission managers, a learning disability advisor, inspectors and

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analysts, senior and junior doctors, senior nurses and midwives, student nurses, a pharmacist, paramedics, a theatre specialist, experts by experience and senior NHS managers.

The community team comprised of a Care Quality Commission senior manager, inspectors and analysts, a

school nurse, a health visitor, a community care nurse, a dentist, district nurses, a community nurse practitioner, a therapy team leader, a palliative care nurse, rehabilitation nurses and experts by experience.

## How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

The inspection team always inspects the following core services at each acute hospital inspection, if they are provided:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients

We inspected and reported on the following-

- Dewsbury and District Hospital, which provided all eight of the core services.
- Pinderfields Hospital, which provided all eight of the core services.
- Pontefract Hospital which provided five of the core services, accident and emergency, medicine, surgery,

maternity and midwifery and outpatients. The hospital only provided children and young people's services within the outpatient and accident and emergency services.

An inspection of the community services provided by the trust was also included in this review, where we looked –

- Community health services for children, young people and families
- Community health services for adults
- Community inpatient services
- End of life care
- Dental services

Before visiting, we reviewed a range of information we held about the hospitals and asked other organisations to share what they knew about the services provided. This included the clinical commissioning groups, NHS England local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits over a period of four days on 15, 16, 17 and 18 July 2014 and we undertook an unannounced visit to Pinderfields Hospital and Dewsbury District Hospital on 27 July 2014.

During the visits we held focus groups with a range of staff, including support workers, nurses, midwives, doctors (consultants and junior doctors), physiotherapists, occupational therapists, health visitors and school nurses, administrative staff and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit, outpatients, A&E department, community inpatient facilities and clinics. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held a listening event on 14 July 2014 to hear people's views about care and treatment received at the hospitals.

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We used this information to help us decide what aspects of care and treatment we looked at as part of the

inspection. We also held community focus groups with the support of Regional Voices who was working with Voluntary Action groups so that we could hear the views of harder to reach members of public.

## What people who use the trust's services say

### Friends and family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Mid-Yorkshire NHS Trust had a response rate of 32.9% in June 2014. This was below the England average. Over 96% of the responses indicated they would be extremely likely or very likely to recommend the trust to friends and family.

### Adult Inpatient Survey 2013

The trust scored about the same as other acute trusts for the areas of questioning including about the doctors and nurses, care and treatment and leaving hospital.

### 2012/2013 Cancer Patient Experience Survey

The trust was in the top 20% of trusts for scores in 10 of the survey questions. It was in the bottom 20% for four of the survey questions.

### Listening events

We held a listening event on 14 July 2014 to hear people's views about care and treatment received at the hospitals. We also held community focus groups with the support of Regional Voices who was working with Voluntary Action groups so that we could hear the views of harder to reach members of public. We also received information from

members of the public via Healthwatch. There was a mixture of positive and negative feedback relating to Pinderfields Hospital and Dewsbury Hospital, however the common themes were poor care and concerns about getting outpatient appointments.

### Patient views during the inspection

During the inspection, we spoke with a number of patients across all three acute sites and in the community services. Patients also contacted CQC by telephone and wrote to us before, during and after our inspection. There was a mixture of positive and negative feedback; however the common themes were the delay in treatment, difficulties with the appointment system and poor care particularly relating to Pinderfields General Hospital and Dewsbury District Hospital.

We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites; 33 were positive and 13 comment cards were negative. The main negative themes were long waiting times for outpatients appointments and in accident and emergency department, car parking cost and availability, the condition of Dewsbury District Hospital and concerns about care provided on elderly care wards. The positive themes related to experiences at Pontefract Hospital and the caring staff across all sites.

## Facts and data about this trust

- In 2012/13 the trust had 153,990 inpatient admissions, 456,169 outpatient attendances and 226,583 attendances at accident and emergency.
- The GP registration data shows that the percentage of the population registered with a GP in Wakefield is

99.9% and in Kirklees is 97%. Of all 362 Local Authorities in England, Wakefield and Kirklees are ranked as the 67th and 77th most deprived, respectively. Both results are significantly worse than the England average.

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## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>Staffing levels and skill mix were identified as a significant concern across a number of services and locations, particularly within the acute services. Within medical and surgical services, staffing levels regularly fell below the planned numbers to meet patients' needs or they had shifts without the full range of staff skills needed. Staffing levels within the medical services, maternity services, accident and emergency departments, children's services and on the acute respiratory care unit on G20, where care was provided to Level 2 patients, did not always meet best practice and national guidance. Within end of life care in the acute hospitals, the shortage of staff was impacting on the safety and quality of care given. Staffing was not a significant issue within community services with the exception of community inpatient facilities.</p> <p>The trust used a significant number of temporary staff including agency, bank nurses and locum medical staff. We found this to be the case in relation to all grades of staff. Staff told us that although staffing establishments were improved with bank and agency staff, there were sometimes problems with the skill mix of staff who could not always perform all of the tasks required of them, such as taking blood and inserting cannulas.</p> <p>The divisional team had highlighted that Gate 20 was an outlier in May 2014 for staffing levels and patient safety issues and an improvement plan was in place. However, during the inspection we had serious concerns about the shortages of staff and the risks to patient safety on Gate 20 and drew this to the attention of the trust. The trust reviewed the staffing levels and care on this ward and closed six beds to bring the registered nurse staffing ratio to 1:8. We observed this had been maintained at our unannounced visit on the 27 July 2014. However, following our unannounced inspection, we received concerning information regarding patient safety and nurse staffing numbers on Gate 20. As a result, we asked the trust to provide information on patient and staff numbers for the period of 27 July to 21 August 2014. We found on Gate 20 the beds which had been closed during our inspection had been re-opened and the majority of the shifts did not meet nurse to patient ratios, particularly on night shifts. After reviewing duty rotas provided by the trust we found on the night shifts between 27 July to 21 August 2014 there were 13 shifts which did not meet the trusts minimum staffing levels. On some shifts, for example 3 and 4 August 2014, there was one nurse to 22 patients.</p>	<p><b>Inadequate</b> </p>

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We received a further report from the director of nursing on 26 August 2014 which stated the number of nurses on duty on 3 and 4 August 2014 meant there was a nurse to patient ratio of one nurse to 15 patients. In the report it stated that during these periods additional support had been provided by the weekend ward sisters team, the clinical site managers and night matrons who visited the ward regularly. However it was not clear if the additional support was available on the ward for the duration of the shift. This also meant the off-duty did not provide an accurate reflection of the number of staff working on the ward.

There had been four never events at the trust (April 2013 – March 2014). There were procedures for investigating, including reporting to committees and sharing lessons learnt from these. Key findings were presented to the Patient Safety panel. Arrangements were in place to identify themes and key learning points, which were reported to staff in the patient safety bulletins. These were circulated to all staff via email on a weekly basis.

Areas we visited were visibly clean. Infection rates for *Clostridium difficile* and Methicillin-Sensitive *Staphylococcus Aureus* were below expected levels. Methicillin-Resistant *Staphylococcus Aureus* rates were above the expected rates.

The trust was performing worse than the national average for the development of catheter-acquired infections.

The prevalence rate for pressure ulcers was consistently above the average for England from May 2013 to May 2014. The staffing level of the tissue viability nurse (TVN) team was last reviewed in 2012. The TVN team were reactionary and felt unable to develop the service.

The appropriate arrangements were not always in place for dealing with the storage, handling administration and recording of medication, particularly within the acute services.

There was a significant backlog of outpatient appointments. At the time of our inspection there were approximately 9,500 patients awaiting to be provided with a follow-up appointment. This meant patients were waiting considerable amounts of time to be seen for their follow up appointment. There had been a validation process in place, which had reduced the numbers waiting. It was unclear from the Trust's validation process how they had assessed or identified patients whose condition may have deteriorated in the time between their original appointment and their follow-up appointment.

For full details, see the individual location reports for the inspection of this provider.

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## Are services at this trust effective?

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

Overall, treatment and care was delivered in line with national and best practice guidance. The draft quality account for 2013/14 indicated that the trust participated in 91% of the national clinical audits and 100% of the confidential enquiries it was eligible to participate in. A further 213 local audits were completed in 2013/14. Examples of learning were included in the quality account and had been disseminated to the divisions.

There was no evidence of risk for in-hospital mortality using the hospital standardised mortality ratio indicators or the summary hospital-level mortality indicator.

Pinderfields Hospital was performing worse than the England average for the Myocardial Ischemia (heart attack) National Audit Project indicators and the National Diabetes Inpatient Audit. The stroke services at Pinderfields Hospital were assigned a grade of E (worst) by the Sentinel Stroke National Audit Programme 2013. Although an Annual Stroke Peer Review (18 March 2014) found services had improved, but concerns were raised over staffing levels.

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

There were inconsistencies in recording of decisions over whether to attempt cardio-pulmonary resuscitation. We had serious concerns about the way mental capacity assessments were undertaken and the lack of staff awareness and knowledge.

Most community services demonstrated they were effective, with the exception of the community inpatient facilities. There was evidence that performance was reviewed and actions were in place to improve outcomes across the different teams. Services were meeting the targets in relation to the Healthy Child Programme and some outcomes framework indicators, such as school readiness were above the national average. We saw services, such as the home intravenous antibiotic service, was effective in reducing the number of hospital admissions. However, the inpatient community facility had 23.4% of patients readmitted to an acute hospital bed within 30 days of admission; this was against a trust target of less than 5%.

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For full details, see the individual location reports for the inspection of this provider.

## Are services at this trust caring?

Overall, patients we spoke with were content with the care they received from staff, although a number commented that staff did the best they could despite how busy they were and the pressure they were under.

Patients raised no concerns about their privacy and dignity being compromised and on the whole staff were thought to be polite, patient and caring.

We found some examples of outstanding practice, particularly with the children's community end of life care team (Jigsaw). They demonstrated outstanding compassion and commitment to families. For example, they helped parents and families create physical memories of their child such as a plaster cast of their child's hand so they continued to have a hand to hold.

For full details, see the individual location reports for the inspection of this provider.

Good



## Are services at this trust responsive?

Some areas, including community services, demonstrated they were responsive to the need of patients. Patients in the community who needed to be seen promptly were seen within two hours by the nursing teams and therapists responded to community referrals made by the Accident and Emergency (A&E) departments within 30 minutes. A new 'Proof of Concept' team within community nursing was further improving the responsiveness of services by ensuring an integrated approach to patient care which included social care and the independent sector.

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

The trust had recognised that access and flow of patients through the hospital could be improved and plans had been proposed and were in place to do so. Medical patients, often 20 to 30 a day, were on surgical wards, which may have meant there was a risk that they

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were cared for by nursing staff that might not have been trained in their medical speciality. The trust was significantly higher (38%) than the England average (21%) for delayed transfer of care while waiting for further NHS non-acute care.

Within outpatients, there was a lack of robust accurate audit data in relation to clinic cancellations and delays. The trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%.

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

There were high numbers of complaints regarding outpatients going back many months reporting distress and frustration at delays in accessing appointments, multiple cancellations of appointments, changes in location of appointments and the poor communication with the services.

For patients whose first language was not English, interpretation services were available. There was no visual patient information available in different languages.

## Are services at this trust well-led?

There had been changes at executive and senior management level since May 2012. The Chair and Chief Executive had originally been brought into oversee an improvement and recovery programme, as the trust had been on the verge of administration. Changes had led to a leaner senior management structure. Changes within management had been implemented at all levels of the organisation, which led to a feeling of instability in some areas. This manifested itself in low staff morale, demonstrated in poor staff survey results. Some areas expressed optimism for the future.

The trust had been on the verge of administration up to two years earlier with a large underlying financial deficit, which had a significant impact on the provision of services. The director of finance had developed a financial plan supported by robust quality impact assessments and was confident that the financial gains made over the recent months could be sustained and improved upon.

The leadership team, recently confirmed in post, had introduced a range of initiatives with the aim to improve the governance arrangements within the trust and improve service quality. These

Requires improvement



# Summary of findings

included new corporate governance arrangements to monitor the performance and quality of services. The introduction of the integrated patient experience feedback report was one example where information from a range of sources such as patient surveys, complaints and incidents was brought together to give a holistic picture of care delivery.

However, risk was not always well managed within the trust. Despite the identification of risk and poor performance, actions taken to address or mitigate the risks were not always embedded in practice or sustained in the long term. The information reported to the Trust Board was not always timely or robust. Serious concerns were escalated appropriately but actions on many occasions were reactionary and short lived. For example, we found that concerns over the staffing levels on one ward had been escalated to the trust both internally and externally with regard to staffing levels and poor patient care. Actions had been taken but not sustained and the same issues of concern were repeated putting patients at continued risk.

The leadership team aimed to change the culture within the trust so that working relationships were built on openness and honesty. Improved incident reporting was one driver for change, to be seen as a positive action, rather than one shrouded in blame and suspicion. Greater staff engagement had also been introduced with increased visibility of the leadership team. Many of the changes in governance and strategies had only been introduced over the last few months, and it was too early to assess whether the changes would be sustained in the long term and bring about the cultural change desired.

Although a few community services teams felt integrated with the rest of the trust, some felt they were not part of the wider trust. Performance management and understanding of the developments in community care by senior managers in the trust was limited

## **Vision and strategy for this service**

- The trust had a strategic vision – ‘One team providing the best care for our patients’ and aimed to improve the standard of urgent care through the development of care closer to home.
- The trust’s vision, values and strategy had been cascaded to wards and departments. This was displayed throughout the trust.
- Some staff had a clear understanding of what these involved, but this was not the case in all areas.

# Summary of findings

- The trust was still in recovery from a historic financial deficit. There was a financial plan in place supported by a robust quality impact assessment process. The financial director was clear that quality drives improvement, but the trust was on a 'journey' and that there was still much more to do and embed.

## **Governance, risk management and quality measurement**

- The trust had a Board Assurance Framework in place to monitor the delivery of its key strategic objectives. A governance and reporting structure had been developed to give the Board assurance that any risks were appropriately mitigated. Risks identified the relevant strategic objective and a scoring system was used to identify the level of risk and likely impact. To underpin this system a corporate risk register was in place that recorded risks to the Board over a certain score.
- We found that risks were identified and assessed at team and divisional level. The higher scoring risks were then escalated up to the Board. However, we found that these local risk registers were of variable quality; some described an incident rather than identifying the risk. There were multiple versions in existence and not all senior managers were sighted on the risks contained within them. This meant that there was a risk of confusion, the potential for inappropriate or delayed action at the local level, but also assessment of risk at Board level could be based on inaccurate information.
- Risks had been identified by the trust, but for some of them insufficient action had been taken to address them or sustain changes where these had been made.
- The trust was aiming to be one of the top incident reporters nationally as part of embedding a safety culture in the trust. However, it was reported in May 2013 there was a backlog of 2806 outstanding incident investigations which had built up requiring a review of the incident reporting and investigating arrangements. These had been reduced to 500. We were informed that by July 2014, these had further decreased to 188.
- We found the trust had initially identified concerns with follow up appointments in Ophthalmology in July 2013 and ENT in September 2013. On further investigation the trust had found this was an issue across other services.
- However despite issues being raised in Ophthalmology in July 2013 and then wider trust concerns about follow up appointments being raised in September 2013 the Trust between July 2013 and March 2014 had not put adequate

# Summary of findings

measures in place to manage the backlog of appointments.

Since March 2014 Specialty level action plans have been in place as a result the back log had been reduced by approximately 10,000 between March and July 2014.

- The trust has continued to experience issues with the cancellation of outpatient appointments since 2010. This continued to be a major issue of concern for the trust at the time of our inspection. Therefore, despite awareness, actions taken to address this matter were ineffective, which continued to put patients at risk due to delays in treatments.
- There were inconsistent practices across hospital sites, particularly in the mortuary services and not all actions identified in action plans following incident investigations were embedded in practice.
- As part of our inspection CQC raised concerns with the Chief Executive about patient safety and nurse staffing on Gate 20. The trust implemented a number of immediate actions to address the concerns which included reducing the number of beds on the ward from 46 to 40.
- The trust provided information about Gate 20 after our announced visit to detail the actions they had taken. In this review it stated a review of Gate 20 had taken place in May 2014. This was undertaken by the senior nursing team following increasing concerns about the evidence of patient harm on the ward. This included three severe incidents reported between April and June 2014 associated with the care delivered to patients on the ward. An action plan had been developed and on the week of our inspection one of the matrons had been moved to the ward to implement these actions.
- However, we saw the Local Authority Safeguarding Adult's Board had substantiated an allegation of neglect in December 2013 on Gate 20. Further information came to the trust's attention in May 2014 from their review of the continuing risk of patient harm on the ward. Despite this at the time of our inspection significant concerns remained. This meant the trust had not taken appropriate and sufficient actions to mitigate the risks to patient harm since they first became aware of concerns seven months previously.
- Following our inspection, we received information of concern about Gate 20 in relation to patient safety and nurse staffing numbers. We issued a letter to the trust under Section 64 of the Health and Social Care Act 2008 and required them to provide

# Summary of findings

information on Gate 20. Section 64 of the Health and Social Care Act (2008) gives CQC powers to require any information that it considers “necessary or expedient to have for the purpose of any of its regulatory functions”.

- The trust responded and provided information particularly on patient numbers on the wards, number of beds opened, staffing numbers, risk assessments which had been undertaken and any actions which had been taken to reduce risks identified. We found serious concerns with the continued management of Gate 20. Following our unannounced inspection beds had been re-opened to manage bed capacity issues within the trust however this meant on the majority of occasions nurse staffing numbers did not meet minimum requirements. Between 27 July to 21 August 2014 the trust informed us there had been ten falls on the ward and five incidents of pressure ulcers.
- The director of nursing confirmed to us on the 22 August 2014 beds had been re-closed to maintain nurse patient staffing ratios. The trust was required to provide CQC with regular updates on nurse-to-patient ratios and any patient harm which has occurred. The NHS Trust Development Authority, which has been supporting the trust, has now taken over the monitoring of staffing levels and patient safety on Gate 20.
- Wards used and displayed quality information and the safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action plans were put in place to improve performance. The timeliness of action following concerns being raised was not as responsive as it might have been. For example, an action plan was produced for Gate 20 (dated 23 June 2014) that included, “Management of and maintaining safe staffing levels 1:8 as a minimum”. This had not been implemented at the time of our inspection.
- From analysis of Board and committee papers, we found that there had been a long standing issue over the age and effective use of equipment used in the pathology services. Problems experienced were frequent breakdowns and quality failures leading to potential risks to the accuracy of results. An incident had occurred in April 2013; and as a consequence 300 patients’ samples had to be re-tested. We were assured by the trust that this had been a low risk issue and no patients experienced harm. The trust had been aware of the age of the equipment and had started procurement procedures after many of the machines were past their lifetime replacement age. We were informed that delays had taken place due to legal reasons,

# Summary of findings

which were now resolved and that arrangements had been put in place to for the maintenance of equipment and checks ensured the integrity of results. This issue had not been resolved at the time of our inspection.

- The prevalence rate for pressure ulcers was consistently above the average for England from May 2013 to May 2014. Root cause analyses (RCA) of category 3 and 4 pressure ulcers were presented to weekly trust-wide-pressure ulcer panels. However, the panel for 3 consecutive months specified that the “standard of the RCA investigation and completeness of the RCA document must improve.” The pressure ulcer panel on 1 July 2014 had seven RCAs scheduled for review. One RCA was presented; all others required further action plans or, in four cases, no RCA was presented. Ward sisters or team leaders undertook the RCA. This was reviewed by matrons. Between May 2013 and July 2014 6 community nursing staff and 12 acute nursing staff had undertaken RCA training; no matrons had received RCA training or update training during this period. We were not assured that staff undertaking RCAs had received the appropriate training. A pressure ulcer summit was planned for August 2014. However, at the time of inspection there was no trust-wide action plan and insufficient action had been taken to address the high prevalence rates of pressure ulcers across the trust. Since the inspection the trust has made us aware that there is an action plan in place and we are following this up.
- The incidence of reported medication errors for 2013/14 was 766 which were higher than the trust’s trajectory of 550. The issue had been discussed at the trust’s Clinical Executive Group and patient safety dashboard meeting since August 2013. One of the trust’s quality indicators for 2013/14 was to increase the volume of incidents reported. It was not clear whether the number of reported medication errors was due to more reported incidents or whether more medication errors had occurred.
- Routine community services’ performance information was identified by senior managers as an area of development. A draft quality dashboard had been developed, but further work was required to provide information to the board.

## Leadership of service

- There had been changes at executive level over the last two years. Changes had led to a leaner senior management structure.

# Summary of findings

- Changes had also taken place within clinical service management with the creation of three clinical service divisions, medicine, surgery and integrated care. Each clinical service was led by a divisional clinical lead, an associate director of nursing and associate director of operations.
- The Chief Executive was passionate about patient care and reported that he had a clear understanding of the trust challenges. He was ambitious for the organisation to change and improve the quality and delivery of services and had made changes in the executive and senior management team to bring the necessary changes about.
- There was inconsistency in views about the leadership by staff spoken with; some felt the new leadership team, particularly the Chief Executive was more visible, and others felt more excluded, particularly at Pontefract Hospital and in the community services.
- Leadership in some areas such as medical care had lacked stability and direction because of many staff changes. The senior division leadership in the medical division had all been in post for less than a year. Other areas expressed optimism for the future. In areas, such as outpatients and community inpatient areas, managerial staff were in interim positions. Staff were concerned there may be further changes to management.

## **Culture within the service**

- There were low levels of morale amongst the staff group and disengagement between staff and the trust leadership team. Many staff reported feeling insecure with the reconfiguration of services at the trust and unsure about the implications for their futures. The trust had started to implement strategies to increase staff morale including increased staff engagement and listening initiatives.
- There had been three episodes of industrial action relating to the major workforce re-profiling.
- The Staff Survey 2013 found the trust to be in the worst 20% for staff recommending the trust as a place of work or to receive care; 60% of staff stated there were not enough staff in the trust for them to do their job properly.
- Staff felt proud of their individual areas and teams they worked in but frustrated and demoralised about their inability to offer a good service to patients due to staff shortages. The continuous movement and borrowing of staff from their normal working

# Summary of findings

area to support staff where there were staffing issues was adding to the stress and tension felt. The chaplaincy services reported increasing numbers of staff seeking support and counselling due to work stress and pressures.

## Public and staff engagement

- We looked at the NHS staff survey results for 2013 and saw that the levels of staff receiving job-relevant training, learning or development in the 12 months leading to the survey were in the worst 20% when compared with other trusts. We received feedback from staff about mandatory training. Staff told us that training was available but that staffing levels on the wards meant they could not always attend training.
- The trust had launched a programme of staff engagement and listening initiatives with the aim to improve staff involvement in service delivery and increase job satisfaction. Action plans had also been developed to address issues raised in the staff survey.
- There had been new strategies introduced to understand the patient experience, learn from this and make improvements in service delivery. A review of the complaints handling system had taken place and included new reporting and investigation arrangements. The trust's performance on complaints was incorporated into the chief nurse monthly report to the Trust Board and included data on the numbers and grading of complaints, trends by division and examples of service improvement. There had been improvements in the response times with complaints. However, we found that the reporting to the Board captured information on formal complaints only, when the majority were informal. Informal complaints were being analysed and captured in the integrated patient experience reports and action plans were developed from these to be delivered at local level. However, this meant that there was a risk that the Board would not be fully sighted on the many themes and issues captured in these reports and make decisions based on formal complaint trends only.
- There was a customer care strategy, which commenced with the launch of the 'Striving for Excellence' programme with five breakthrough objectives and a zero tolerance to poor customer care.
- Patient stories were heard at the Trust Board meetings and there was an intention to increase engagement with patients and the public. There were a limited number of patient representative groups in place but plans were in place to increase these.
- The trust engaged externally with patient representative organisations such as Healthwatch, which we saw took part in

# Summary of findings

monthly safety workarounds with the clinical commissioning groups. The trust also engaged with other local stakeholders and we found that many of the concerns raised as part of this inspection and previous concerns were shared with commissioners. The leadership team aimed to be transparent with external stakeholders, and build working relationships with them.

## **Innovation, improvement and sustainability**

- We saw examples of innovative practice such as the 'Green card' scheme launched with Macmillan cancer services. This supported the use of a credit card sized green card with contact details for patients for the specialist palliative care team and other healthcare professionals including district nurses. Patients were encouraged to show this if admitted to hospital or requiring out of hours support to indicate to others that they are known to specialist palliative care services.
- There was also provision of integrated, multidisciplinary community health and care services. The team was newly created and consisted of community matrons and nursing staff, therapists, dedicated social workers, a full time pharmacist and the independent/charity sector. This meant the team was able to address patients' needs from assistance with shopping through to social care packages and intensive therapy, pharmacy and nursing input. This was locally well-led. However, senior managers at the trust had not identified this as an area of innovative practice.
- Although there were areas of innovation, we were concerned about the ability across the trust to support and sustain other areas of improvement.
- Staff raised concerns about the number of staff in interim posts in relation to the sustainability of the service. This led to a feeling of uncertainty amongst staff.

# Overview of ratings

## Our ratings for Pinderfields Hospital

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

## Our ratings for Dewsbury District Hospital

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

# Overview of ratings

End of life care	Inadequate	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Requires improvement	Inadequate
<b>Overall</b>	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

## Our ratings for Pontefract Hospital

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

## Our ratings for Community services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Outstanding	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Requires improvement	Good
Community health inpatient services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Outstanding	Good	Good	Good

# Overview of ratings

Community dentistry services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

## Our ratings for Mid Yorkshire Hospitals NHS Trust

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

# Outstanding practice and areas for improvement

## Outstanding practice

- The provision of integrated, multidisciplinary community health and care services. The team was newly created and had already seen over 400 patients. The team was made up of community matrons and nursing staff, therapists, dedicated social workers a full time pharmacist and the independent/charity sector. This meant the team was able to address patients' needs from assistance with shopping through to social care packages and intensive therapy, pharmacy and nursing input.
- Health visiting teams had implemented a link Health Visitor role to liaise with safeguarding GPs to work closely with GP practices to promote effective communication and share good practice.
- Staff within the children's community end of life care team (Jigsaw) demonstrated outstanding compassion and commitment. They helped parents and families create physical memories of their child such as a plaster cast of their child's hand so they continued to have a hand to hold.
- The urology department had been recognised nationally for the use of green light laser surgery, which is a minimally invasive procedure for prostate symptoms. The procedure enabled patients to return home within a few hours and return to normal activities within days.
- Patients discharged from the critical care unit were invited to attend a monthly outpatient clinic run by staff from the critical care service. Patients could be referred from the clinic for psychological support if this was needed.
- The children's service had developed a 'patient group directions competency assessment' support package for the nursing team. The package ensured the nurse had read and understood patient group directions before testing their knowledge and understanding.

## Areas for improvement

### Action the trust MUST take to improve

The trust put in actions to address concerns over Gate 20 and other concerns raised within this report and presented these at the Quality Summit on 13 October 2014. At the summit the trust gave assurance that they had taken immediate action to address serious concerns including the application of the Safer Nursing Tool, benchmarking practice over staffing with other trusts, appointing a Mental Capacity Act 2005 advisor, improved training and additional auditing systems.

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

### Importantly, the action the trust MUST take to improve

- Ensure that the reporting of risk and unsafe care and treatment is robust and timely to the Trust Board so that appropriate decisions can be made and actions taken to address or mitigate risk to patient safety.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Address the backlog of outpatient appointments, including follow-ups, to ensure patients are not waiting considerable amounts of time for assessment and/or treatment.
- Ensure clinical deteriorations in the patient's condition are monitored and acted upon for patients who are in the backlog of outpatient appointments.
- Review the 'did not attend' in outpatients' clinics and put in steps to address issues identified.

# Outstanding practice and areas for improvement

- Ensure the procedures for documenting the involvement of patients and relatives in 'Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR)' are in accordance with best practice at all times.
- Ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- Ensure recommendations from serious incidents and never events are monitored to ensure changes to practice are implemented and sustained in the long term.
- Ensure there are improvements in referral to treatment times to meet national standards
- Review the skills and experience of staff working with children in the A&E departments, special care baby unit and children's outpatients' clinics to meet national and best practice recommendations.
- Ensure staff are clear about which procedures to follow in relation to assessing capacity and consent for patients who may have variable mental capacity. This would ensure staff act in the best interests of the patient in accordance with the Mental Capacity Act 2005 and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure all staff attend and complete mandatory training and role specific training, particularly for safeguarding and resuscitation. In addition ensure all staff working in urgent care settings undertake where appropriate have Level 3 safeguarding training.
- Ensure staff receive training on caring for patients living with dementia in clinical areas where patients living with dementia access services. In addition where appropriate ensure staff are trained on the End of Life care plan booklet and updated on the trust's new policy
- Ensure that issues with replacing pathology equipment are addressed to ensure that equipment is fit for purpose.
- Ensure the pharmacy department is able to deliver an adequate clinical pharmacy service to all wards.
- Ensure staff are trained and competent with medication storage, handling and administration.
- Ensure controlled drugs are administered, stored and disposed of in accordance with trust policy, national guidance and legislation.
- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure equipment in the Accident and emergency department is appropriately cleaned and labelled and then stored in an appropriate environment.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) is embedded in theatre practice.
- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure 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
- Ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Review the arrangements over the oversight of Gate 20 acute respiratory care unit to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013).
- Ensure the recommendations from the mortuary review are implemented and monitored to ensure compliance.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.
- Ensure actions are taken to address the poor decorative state of the mortuary to ensure effective and thorough cleaning can be undertaken. (Dewsbury)

# Outstanding practice and areas for improvement

## Action the trust **SHOULD** take to improve

- The trust should review the service to improve in the number of emergency admissions following an elective surgical admission.
- Ensure information leaflets for relatives and carer's of dying patients are updated following the withdrawal of the Liverpool care pathway.
- The trust should review their lone working policy and its implementation as well as their anticipatory planning for major events.
- The trust should review the recording of consent in community children's services.
- The trust should improve staff engagement between frontline staff, team leaders, middle management and the board.
- The provider should take steps to ensure the community inpatient facilities referral criteria are applied consistently.
- The trust should ensure at board level there is an identified lead with the responsibility for services for children and young people.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>People who use outpatient services were not protected from the risks associated with treatment delays at outpatients because the trust had not ensured that patients received an outpatient appointment in a timely way.</p> <p>End of life care patients who use services did not have their care planned or delivered in a way which met the individual person's needs because a care plan, to replace the Liverpool Care Pathway, was not in place.</p> <p>People who use services in medical and surgery services were not protected against the risks associated with pressure ulcers because the trust had not planned or delivered care or treatment in a way that ensured the welfare and safety of the patient.</p> <p>The WHO safer surgery checklist was not routinely completed in surgery to ensure the safety and welfare of the patient.</p> <p>Only 95% of resuscitaires in maternity at Dewsbury and District Hospital had been audited and checked to ensure the safety and welfare of babies.</p> <p>Regulation 9 (1)(a) ,(b)(i) and (b)(ii) HSCA 2008 (Regulated Activities) Regulations 2010: Care and welfare of service users.</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p>

This section is primarily information for the provider

## Compliance actions

Patients were not protected from the risk associated with unsafe care or treatment because the trust had not fully implemented the requirements of the NICE clinical guideline CG83: Rehabilitation after critical illness at Dewsbury and District Hospital.

Patients were not protected from the risk associated with unsafe care or treatment because the trust had not implemented or embedded a policy or procedure for the transition of care between children and younger persons and adult healthcare services.

Regulation 10 (2)(c)(iii) HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

In the mortuary at Dewsbury and District Hospital the trust had not ensured, so far as reasonably practicable, because we observed poor infection control practices which did not ensure staff, or

undertakers were protected from the risk of the spread of infection. Mortuary staff were observed wearing their own clothing with a long sleeved laboratory coat, this was observed to have some stains on it. The mortuary trolley was not routinely cleaned after each use. Due to the poor state of decorative repair with damaged walls and broken tiles the mortuary could not be effectively cleaned.

At Pinderfields Hospital we found that there were issues over the management of soiled and contaminated linen. Some of the linen used when relatives viewed deceased patients was stained and red bags of potentially infected linen were observed left on the floor, increasing the risk of the spread of infection.

Regulation 12 (2)(a),(b) and (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010: Cleanliness and infection control.

### Regulated activity

### Regulation

This section is primarily information for the provider

## Compliance actions

Treatment of disease, disorder or injury

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

The trust had not made suitable arrangements to protect patients because the equipment used in pathology had not been properly maintained and risked patients receiving inaccurate test results or delayed test results.

Regulation 16 (1)(a) HSCA 2008 (Regulated Activities) Regulations 2010: Safety, availability and suitability of equipment.

### Regulated activity

### Regulation

Surgical procedures

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Treatment of disease, disorder or injury

The trust did not have suitable arrangements in place for obtaining consent from children because the trust does not have a current policy for children and young people within the children's service.

The trust did not act in accordance with the best interests of the patient towards the end of their life because do not attempt cardiopulmonary resuscitation orders (DNACPRs) were not always completed appropriately.

Outpatient services could not demonstrate that they met the requirements of Section 4 of the Mental Capacity Act 2005 (best interests) because only 68% of their staff had received appropriate training on this subject.

The division of surgery services could not demonstrate that they met the requirements of Section 4 of the Mental Capacity Act 2005 (best interests) because only 69% of their staff had received appropriate training on this subject.

The division of medicine could not demonstrate that they met the requirements of Section 4 of the Mental Capacity Act 2005 (best interests) because only 68% of their staff had received appropriate training on this subject

Regulation 18 (1)(a) and (b) and 18(2) HSCA 2008 (Regulated Activities) Regulations 2010: Consent to care and treatment

This section is primarily information for the provider

## Compliance actions

### Regulated activity

Maternity and midwifery services  
Treatment of disease, disorder or injury

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations  
2010 Staffing

The trust has not safeguarded the health, safety and welfare of service users because appropriate steps have not been taken to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed or retained for the purposes of carrying on the regulated activity. At Pinderfields Hospital the theatre vacancy rate has increased from 6.8% to 7.8%. There are also significant staff shortages on Gate 12, Gate 20, Gate 38, Gate 41, Gate 42 and ward A2 where a high proportion of agency staff are in use to increase numbers. The recording and monitoring skill mix and competency for all agency staff has not been evidenced.

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

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

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe because staff in the divisions of medicine and surgery were not fully aware or up to date with the national guidance and good practice in relation to Deprivation of Liberty Safeguards (DoLS).

Regulation Reg 11(2)(a) and (b) of the Regulated Activities Regulations 2010, Safeguarding service users from abuse.

#### Regulated activity

Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

Appropriate arrangements were not in place for dealing with the storage, handling, administration and recording of medication.

At Pindersfield Hospital medicines, including controlled drugs, were not always correctly stored or disposed of in accordance with trust policy, national guidance and legislation.

A recent medicines management audit from the trust demonstrated that the safety of medicines had broadly not improved since 2012.

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines.