The Mid Yorkshire Hospitals NHS Trust

Pontefract Hospital

Quality Report

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

Ratings

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

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. At Pontefract, the trust had approximately 61 general and acute beds and four beds in Maternity. The trust also employed 7,948 staff, of which 536 were based at Pontefract. This included 28 medical staff and 261 nursing staff.

We carried out a comprehensive inspection of the trust between 16 and 19 May 2017. This included unannounced visit to the trust 11 and 22 May and 5 June 2017. The inspection took place as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust and to follow up on progress from our previous comprehensive inspection in July 2014, a focused inspections in June 2015, and unannounced focused inspection in August and September 2015. 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.

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.

At the inspection in July 2015 and our follow up unannounced inspections, we found that the trust was in breach of regulations relating to safe care and treatment of patients, addressing patients nutritional needs, safe staffing, and governance. We issued requirement notices to the trust in respect of these breaches.

Our key findings from our inspection in May 2017 are as follows.

We rated Pontefract Hospital as requires improvement because:

- Nursing and medical staffing in some areas was a concern. In the emergency department nurse staffing was not always meeting planned staffing levels or national guidance. Nursing staff were frequently being moved to wards to cover staffing shortages. Midwifery staffing was below nationally recommended levels and community midwifery caseloads were above the national recommendations.
- Access and flow was a challenge at this hospital. We saw that the hospital was failing to meet the majority of national standards relating to Accident and Emergency performance, including: four hour waits, re-attendance rates, time from decision to admit to admission, median time to treatment and ambulance handover times. However, recent information showed that performance was improving.
- Patients had long waits in the emergency department once a decision to admit them had been made. This was predominantly due to the lack of beds available to admit patients in to the trust, although mental health patients were also affected. Women experienced long waits at the antenatal clinic, and some were required to stand, as there was not enough seating.
- There were issues regarding referral to treatment (RTT) indicators and waiting lists for appointments. There was an appointment backlog which had deteriorated since the last inspection and was at 19,647 patients waiting more than three months for a follow up appointment. Staff told us clinical validation had occurred on some waiting lists, for example in ophthalmology. However, this had not occurred on all backlogs across the trust. Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Summary of findings

- Staff across most specialties were not meeting the trust's mandatory training and appraisal targets. We were not assured of the competence of midwifery staff with regard to basic skills such as cannulation and perineal suturing.
- Recording of pain scores and National Early Warning Scores (NEWS) was not consistent and some audits identified a deterioration in compliance with recording NEWS scores.
- We were not assured that all staff were competent to use medical devices. There was also limited assurance that electronic equipment had annual safety checks.
- Although there was a newly implemented governance process, this was yet to be embedded in practice. The emergency department did not take part in RCEM or clinical audits and therefore there was no assurance that standards of care were being met. The maternity risk register contained a large number of risks, and many had a review date in the past. This led to concern that the risk register was not being appropriately scrutinised. Duty of candour was not well understood across all staff groups; however senior managers could describe the duty of candour.

However,

- Patients received care and treatment that was caring and compassionate from staff who were working hard to make sure that patient experience was positive and supportive. Staff were able to meet the physical and emotional needs of patients. There was access to pastoral support for patients of any or no religion.
- A trust incident reporting system was used to report incidents and staff we spoke with were aware of how to report incidents. Staff were aware of how to report safeguarding concerns. We saw evidence that Root Cause Analysis (RCA) and investigations of serious incidents were comprehensive .
- Patients had good outcomes from surgery and they received effective care and treatment to meet their needs. The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care.
- There were clear governance processes in place. Management could describe the risks to the service and the ways they were mitigating these risks. Services were engaged in reviewing staffing levels and considering how staffing concerns could be addressed via recruitment and the introduction of new staff roles.
- Staff praised the executive management team of the trust and told us that since our last inspection the atmosphere of the trust felt different. Staff were positive about the future and felt that problems were now more open and being addressed by leaders.

Importantly, the trust must:

- Ensure that mandatory training levels are meeting the trust standard.
- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.

In addition the trust should:

- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.
- Ensure that all staff have annual appraisals.
- Continue to focus on achieving A&E standards and ensure that improved performance against standard is maintained.
- Ensure that records are completed fully and that records are stored securely.

Summary of findings

- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians.
- Continue to address issues of non-compliance with referral to treatment indicators and the backlog of patients waiting for appointments.
- Ensure work to improve the completion of consent forms in line with trust expectations.
- Review the risk registers and remove or archive any risks that no longer apply.
- Increase local audit activity to encourage continuous improvement.
- Ensure it continues to address capacity and demand across all outpatient services.
- Consider ways of ensuring team meetings in main outpatients are regular and consistent.
- Consider ways of ensuring environmental compliance issues with carpets in departments.
- Improve the assessment and recording of patient pain scores.
- Ensure there are appropriately qualified or experienced children's nurses in ED.
- Undertake clinical audit in ED to ensure that national and local standards of care are being met.
- Improve the reliability of the blood diagnostic service.
- Ensure that robust recruitment and retention policies continue, to improve staff and skill shortages; with particular emphasis on theatre recruitment.

Professor Edward Baker

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 	The department was failing to meet the majority of national standards relating to Accident and Emergency performance, including: four hour waits, re-attendance rates, time from decision to admit to admission, median time to treatment and ambulance handover times. However, recent information showed that performance was improving. Staff were not meeting the trust's mandatory training targets and we had concerns about the robustness of the triage training process because inexperienced nurses were being trained to carry out triage. Additionally nursing staff were not receiving annual appraisals. Nursing and medical staffing in the department was not always meeting planned staffing levels and nursing staff were frequently being moved to wards to cover staffing shortages. Recording of pain scores and National Early Warning Scores (NEWS) was not consistent. Additionally, the Pontefract department did not take part in RCEM or clinical audits and therefore there was no assurance that standards of care were being met. Patients had long waits in the department once a decision to admit them had been made. This was predominantly due to the lack of beds available to admit patients in to the trust, although mental health patients were also affected. Although there was a newly implemented governance process, this was yet to be embedded in practice. However: The department was aware of its problems and risks and had changed practice and processes in an attempt to tackle them, such as the introduction of new nursing roles. Patients received care and treatment that was caring and compassionate from staff who were working hard to make sure that patient experience of the department was positive and supportive. The department was able to meet the physical and

emotional needs of patients. Specialist equipment was available for bariatric patients and patients with physical disability. There was access to pastoral support for patients of any or no religion. Staff praised the executive management team of the trust and the department and told us since our last inspection the atmosphere of the trust felt different. Staff were positive about the future and felt that problems were now more open and being addressed.

Surgery

Good

Senior nursing staff had daily responsibility for safe and effective nurse staffing levels and staffing guidelines with clear escalation procedures were in place. Appropriate risk assessments were completed accurately for falls, pressure ulcers, National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.

We saw evidence that Root Cause Analysis (RCA) and investigations of serious incidents were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans. We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.

Patients had good outcomes as they received effective care and treatment to meet their needs. The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care. A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity.

There were clear governance processes in place to monitor the service provided. A clear responsibility and accountability framework had been established. The division handled 97% of complaints within trust timescales (95% target). Leadership at each level was visible, staff had

Summary of findings

confidence in the leadership and staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
However:
Medical staff did not meet the trust target for mandatory core training completion, this included safeguarding. Across the division, NEWS audits (March 2017) showed that 59% of observations were recorded which were worse than the 67% compliance rate in the previous audit.
There were 108 medication incidents recorded between March 2016 and February 2017 across the surgical division.
Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Maternity and gynaecology

Good

There were robust practices in place to check emergency equipment. The service had bid successfully for Department of Health Safety training and had allocated the funding appropriately.
Following our previous inspection the service reviewed staffing using a recognised acuity tool and this recommended a shortfall of 18 whole time equivalents. The service had an agreed plan to fill these posts over three years.
The rates of normal birth were better than the England average. We found good multidisciplinary working between midwifery and medical staff. We observed good and friendly interactions between staff, women and relatives. There was sympathetic engagement with staff and patients around the reconfiguration of maternity services.
The service had a comprehensive business plan, which included plans to increase staffing levels including specialist midwifery posts.
However:
We were not assured that staff were competent to use medical devices. There was also little assurance that electronic equipment had an annual safety checks. We were not assured of the competence of staff with regard to basic skills such as cannulation and perineal suturing. Attendance of hospital

midwives at Obstetric emergency training was below the trust target of 95% at 86%. We found a lack of skills and drills scenarios on the Friarwood Birth Centre.
Midwifery staffing was below nationally recommended levels at 1:31. The community midwifery caseloads were above the national recommendations. Women experienced long waits at the antenatal clinic, and some were required to stand, as there was not enough seating.
The risk register contained a large number of risks, and many had a review date in the past. This led to concern that the risk register was not being appropriately scrutinised.

Outpatients and diagnostic imaging	**Requires improvement**		There were issues regarding referral to treatment (RTT) indicators and waiting lists for appointments. There was an appointment backlog which had deteriorated since the last inspection and was at 19,647 patients waiting more than three months for a follow up appointment. Staff told us clinical validation had occurred on some waiting lists, for example in ophthalmology. However this had not occurred on all backlogs across the trust. No specialties were above the England average for non-admitted referral to treatment (RTT) (percentage within 18 weeks), however the trust were progressing work on addressing this with a trajectory to be achieving the indicators by March 2018. The trust did not measure how many patients waited over 30 minutes for imaging within departments. The trust measured turnaround times in a different way from Keogh standards. They measured time taken from referral to report rather than referral to image and a separate measurement of image to report. Although measured differently, trust and national targets were not consistently met. Duty of candour was not well understood across all staff groups; however senior managers could describe the duty of candour. Mandatory training completion rates and targets were not always met. Appraisals completion rates did not always achieve the trust target.

Summary of findings

In main outpatients, team meetings did not always happen monthly. Managers were aware of this and told us they were addressing consistency of team meetings in main outpatients.
However:
A trust incident reporting system was used to report incidents and staff we spoke with were aware of how to report incidents. Staff were aware of how to report safeguarding concerns.
Areas we visited were visibly clean and tidy. Medicines checked were found to be stored securely and were in date. Staff told us records were available for clinics when required.
Actual staffing levels were in line with the planned staffing levels in most areas. Staff provided compassionate care to patients visiting the service and ensured privacy and dignity was maintained. Diagnostic services were delivered by caring, committed and compassionate staff.
Managers were able to describe their focus around addressing issues with the referral to treatment indicators and addressing waiting times. There were referral to treatment recovery plans in place for various specialties. The Did Not Attend (DNA) rate was lower than the England average.
Risk registers were in place and managers took risks to the divisional governance meetings.
Management could describe the risks to the service and the ways they were mitigating these risks. Most staff we spoke with told us managers and team leaders were available, supportive and visible. Staff we spoke with told us there was good teamwork within teams and there was a culture of openness and honesty. Diagnostic imaging leaders encouraged and enabled staff to develop their own skills and knowledge, share good practice nationally, and improve the service.

Pontefract Hospital

Detailed findings

Services we looked at
Urgent & Emergency Services; Surgery; Maternity and Gynaecology; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Pontefract Hospital

Pontefract Hospital is part of the The Mid-Yorkshire NHS Trust. It is situated in Pontefract 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. Pontefract Hospital employs around 446 whole time equivalent staff which included 28 medical staff, 261 nursing staff and 274 other staff. Pontefract Hospital provided a range of services including: accident and emergency, rehabilitation unit, surgical short stay unit, outpatient services for adults and children, day surgery for adults and a midwife-led maternity unit. The hospital has 61 general and acute beds, four maternity beds and a number of day case facilities.

Wakefield is one of the 20% most deprived districts/ unitary authorities in England and about 21% (12,600) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 8.5 years lower for men and 7.8 years lower for women in the most deprived areas of Wakefield than in the least deprived areas. Life expectancy is 7.9 years lower for men and 6.7 years lower for women in the most deprived areas of Kirklees than in the least deprived areas.

Approximately 355,000 people live in Wakefield. This is forecast to grow in line with the rest of England by around 2.8% over the next five years. Population growth will be highest in those aged 65 years and over, where the increase will be by around 14.4%. Approximately 185,000 people live in North Kirklees and this is forecast to grow by 3.8% over the next five years, with those aged 65 and over expected to increase by around 14.3%.

The BAME (Black, Asian, Minority Ethnic) population is noted to be increasing, especially in Batley and Dewsbury where 38% of those aged under 18 are now south Asian. There are a higher proportion of babies being born to south Asian mothers, now up to 2 in 5 births and 38% of all those aged under 18 in North Kirklees. 85% of these are living in Dewsbury and Batley.

We carried out a follow up comprehensive inspection of the trust between 16-19 May 2017 in response to previous inspections in July 2014 and June 2015. Following the announced inspection in June 2015 the CQC received a number of concerns and on further analysis of other evidence an unannounced focussed inspection took place in August 2015 and September 2015.

Our inspection team

Our inspection team was led by:

Chair: Carol Panteli, Director of Nursing and Quality, NHS England

Detailed findings

Inspection Manager: Sandra Sutton, Care Quality Commission

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

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?

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. We also held focus groups a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We carried out an unannounced inspection visits on 11 and 22 May and 5 June 2017. The announced inspection visit was between 16 and 19 May 2017.

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. We also spoke with staff individually as requested.

Facts and data about Pontefract Hospital

At Pontefract, the trust had approximately 61general and acute beds and four beds in Maternity. The trust also employed 7,948 staff, of which 536 were based at Pontefract. This included 28 medical staff and 261 nursing staff.

The trust had a total revenue of over £505 million in 2016/17. Its full costs were over £543million and it had a deficit of over £8 million. During 2016/2017 the trust had 245,330 emergency department attendances, 141,103 inpatient admissions, and 722,632 outpatient appointments.

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	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Notes

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

Urgent and emergency services

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust is made up of three hospital sites: Pinderfields hospital (PGH), Dewsbury and District hospital (DDH) and Pontefract hospital (PGI) each site has an emergency department with total attendances at 234,288 in the year 2015/2016 and 19,500 attendances per month.

Attendance was approximately 120 patients per day on the Pontefract site. This was a 4% increase on the previous 12 month period.

Attendance data showed 44,318 patients attended the Pontefract emergency department (ED) between January 2016 and January 2017. Approximately 25% of patients were aged under 17.

The percentage of A&E attendances at the trust that resulted in an admission was lower than the England average, for 2015/16 for type one - major A&E units. The percentage of attendances which resulted in admission for the trust was 22%, the England average was 27.3%.

The emergency department was open 24 hours a day, seven days a week. Only pre agreed ambulances that met specific criteria were accepted at the department. After midnight, the department was staffed by one GP, an emergency nurse practitioner (ENP), nurses and a health care assistant. The ENP was unable to treat children under one year of age. Sick children in ambulances were taken to Pinderfields hospital. However if a sick child was brought to the department by family or carers, they would be treated and stabilised before being transferred by ambulance to the most appropriate hospital.

The emergency department included a majors area consisting of three trolley cubicles, four closed door cubicles, two trolley cubicles for paediatrics, two trolley resuscitation areas, a triage room and two see and treat rooms.

During our inspection, we visited on one occasion as part of the overall announced inspection. We spoke with three patients and 12 members of staff including nurses, health care assistants and medical staff. We reviewed eight sets of electronic records and documentation and reviewed information provided by the trust and external stakeholders prior to our inspection.

We carried out this inspection because at our last inspection we identified some areas of concern. We asked the trust to make some improvements.There were concerns in regard to;

- Interdepartmental ED learning and sharing of lessons learned from incidents, incidents were shared internally however sharing did not occur between Pontefract and Dewsbury.
- We found toys that were unable to cleaned thoroughly, the recording of fridge temperatures were intermittent, safeguarding information was not always completed accurately whilst children were in the department. Mandatory training rates for medical staff were poor with low levels of compliance.
- Concerns were raised about access to out of hours support service such as radiology scanning and clinical blood testing as they are provided on Pinderfields site. We saw evidence patients experiencing delays in treatments, and testing due to testing equipment on site failing.

Urgent and emergency services

- Staff were concerned about recent changes in the booking of ambulances and recent delays in transfers due to this changing to the booking system from priority one ambulance (life threatening illness or injury); these are often downgraded to a priority two booking systems and concerns around patient deterioration.
- CEM audits were not always undertaken on the Pontefract site despite appropriate patients being identified.
- There was no robust clinical governance structure across the three EDs, Pontefract and Pinderfields held meetings together and Dewsbury held a separate meeting, these meetings were not well attended or documented.
- The risk register was not updated when staff escalated issues for Pontefract to be placed on the risk register. Visibility of the senior management team on the Pontefract site was poor.

At this inspection, we returned to check whether services had improved.

Summary of findings

We rated this service as requires improvement because:

- The department was failing to meet the majority of national standards relating to Accident and Emergency performance including: four hour waits, re-attendance rates, time from decision to admit to admission, median time to treatment and ambulance handover times (however, recent information showed that this was improving).
- Staff were not meeting the trust's mandatory training targets, therefore staff were not up to date with mandatory training. We also identified this at our last inspection. Additionally we had concerns about the robustness of the triage training process because inexperienced nurses were being trained to carry out triage.
- Nursing and medical staffing in the department was not always meeting planned staffing levels and nursing staff were frequently being moved to wards to cover staffing shortages. This left ED short staffed. Additionally nursing staff were not receiving annual appraisals.
- Recording of pain scores and National Early Warning Scores (NEWS) was not consistent.
- Patients had long waits in the department once a decision to admit them had been made. This was predominantly due to the lack of beds available to admit patients in to the trust, although mental health patients were also affected.
- Information for patients in alternative formats such as large print or Braille and other languages was not available.
- Although there was a newly implemented governance process, this was yet to be embedded in practice. Additionally, the Pontefract department did not take part in RCEM or clinical audits and therefore there was no assurance that standards of care were being met.

However:

Urgent and emergency services

- The department had made some improvements. For example, staff were aware of its problems and risks and had changed practice and processes in an attempt to tackle them, such as the introduction of new nursing roles.
- Patients received care and treatment that was caring and compassionate from staff who were working hard to make sure that patient experience of the department was positive and supportive.
- The department was able to meet the physical and emotional needs of patients. Specialist equipment was available for bariatric patients and patients with physical disability. There was access to pastoral support for patients of any or no religion.
- Staff praised the executive management team of the trust and the department and told us since our last inspection the atmosphere of the trust felt different. Staff were positive about the future and felt that problems were now more open and being addressed.

Are urgent and emergency services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- The department had no qualified children's nurses and adult nursing and health care assistant staff were frequently being moved to wards or the ED at Pinderfields to cover staffing shortages.
- Mandatory training levels were not meeting the trust standards. We identified this as a concern at our last inspection.
- We found examples of when staff had not acknowledged the risks of some patients in the department and frequency of observations had not been changed to reflect increased risks. This was for medical patients and patients with mental health concerns.
- The department used an established triage system called Manchester triage. Staff had to complete a workbook to demonstrate competency. There were no criteria about previous experience requirements of nurses before they could complete the training..
- Medical staffing cover between midnight and 8am was provided by GPs rather than specific ED medical staff.

However:

- Incidents were reported by staff and we saw evidence of lessons learned being shared across sites.
- The department was clean and well maintained. There was access to personal protective equipment. Toys and equipment were cleaned regularly and complied with infection prevention and control guidelines.
- Medication was stored safely and securely.
- There were good safeguarding processes in place to ensure that vulnerable adults and children were protected from the risk of abuse.

Incidents

- There were no never events reported by the department at Pontefract. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Urgent and emergency services

- In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in Urgent and Emergency Care that met the reporting criteria set by NHS England between March 2016 and February 2017. The majority of these incidents (six) were "slips/trips/falls". The second most common type was "Sub-optimal care of the deteriorating patient" (three); all three resulted in an avoidable patient death. There was one other serious incident of type "diagnostic incident including delay" that resulted in an avoidable death. There were no serious incidents reported by Pontefract.
- There were 23 incidents between November 2016 and February 2017 at Pontefract Hospital. These related to failures in communication, lack of suitable skilled staff and problems with pathology samples.
- The most commonly reported categories of incidents were regarding lack of suitable trained or skilled staff in the department relating to both reception staff and nursing staff. There had been eight incidents raised due to no reception staff being available, or nursing staff being moved to other wards or sites to cover staffing shortfalls. On one occasion, this had left Pontefract ED below its minimum staffing level.
- Staff told us that they were encouraged to report incidents and had received training to enable them to do so.
- We spoke with staff about their responsibilities around duty of candour. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Most staff were unsure what the phrase meant although they were more familiar with the phrase, 'being open and honest'. Senior staff in the department took responsibility for the formal duty of candour process. They were able to describe it and give examples of when they had used the process.
- We asked staff if they could give us any examples of changes in the department as a result of incidents, but staff were unable to provide us with any examples.
- The trust held regular mortality and morbidity (M&M) meetings and staff frequently attended and discussed relevant cases at team meetings. These had recently been amalgamated across the trust EDs to ensure that lessons were learned cross-site.

Cleanliness, infection control and hygiene

- When we visited the department, we found it to be visibly clean. Patient rooms were cleaned between patients and waiting area floors and seating were in good order.
- There were cleaning schedules in place and we saw completed paperwork confirming that cleaning had been carried out. We saw staff completing the required tasks in line with schedules. At our last inspection we noted that children's toys were not being cleaned regularly. At this inspection we saw a cleaning schedule for toys. We looked at some toys and found that they were clean.
- Patient toilets were clean.
- Staff could call cleaners to the department 'out of hours' if required. However, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
- Staff used 'I'm clean' stickers on equipment to make it clear that equipment was ready for reuse.
- There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection.
- The trust delivered infection prevention and control training every two years. Information supplied showed 88% of nursing staff, 63% of medical staff and 94% of additional clinical staff were up to date with the training. The trust target was 95%.
- The trust routinely monitored staff hand hygiene procedures. We requested copies of hand hygiene audits. The trust sent us an example from August 2016. This showed that the department was not fully compliant. Shortfalls were discussed with individuals and at team meetings.
- The department had an isolation cubicle for patients who required isolation for the prevention and management of actual or potential infection. This cubicle had both doors and curtains to enable isolation and privacy and dignity to be maintained.
- We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment.
- The department sent us evidence of mattress audits. These are regular checks carried out on mattresses to

make sure there is no contamination and risk of infection being passed on whilst using a hospital mattress is minimised. The reports for March, April and May 2017 demonstrated that checks had been carried out. However, the auditor noted that the foam inside the mattresses was marked, cracked or stained. These marks are usually the result of bodily fluids. According to infection prevention and control guidelines issued by the Medicines and Healthcare products Regulatory Agency in December 2014, departments should "Arrange for contaminated mattress cores to be either: cleaned and decontaminated in accordance with the manufacturer's instructions; or safely disposed of. The information in the audit did not state that these mattresses had been condemned.

Environment and equipment

- Consulting and treatment cubicles were an appropriate size and contained the necessary patient equipment. Cubicles had solid walls and either solid doors or curtains to maintain privacy.
- We found that equipment in the department had been safety checked. All the equipment we checked had up to date tests.
- Equipment was serviced and maintained in line with manufacturer's guidelines, as there were maintenance contracts in place. To ensure accuracy equipment was regularly calibrated.
- We saw there were sufficient supplies of all equipment. This meant if one suffered a mechanical breakdown, a spare machine was available.
- There was access to a CT scanner on site Monday to Friday 9am to 5pm. This meant that patients needed to be transferred to another site for CT scans outside of these hours. This could lead to delays in diagnosis or treatment.
- We checked resuscitation equipment during our inspection. All trolleys were ready to be used in an emergency and there were records in place to show that trolleys were checked daily. The trust sent us copies of the checklist for May 2017 up to the date of our inspection. This showed that daily checks had been carried out.
- The waiting area used by patients was adequate with sufficient seating for patients and relatives.

Medicines

- Medication was stored securely in the department. Controlled drugs were stored in line with national and trust policy and stock checks were routinely completed.
- Staff from the pharmacy department completed regular checks of medication stocks held in the department and there was a system in place to make sure that any stock close to expiry was removed.
- Records to show that fridge temperatures were checked were completed regularly.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. Staff had signed to say that they understood them and were working within their guidance.

Records

- The department used a mixture of paper and electronic record in the department. Written records were scanned on the electronic system on a daily basis.
- We looked at the records of seven patients. We found a clear medical history, action plan and treatment plan recorded.
- The records we looked at showed that nursing care, such as supporting patients to eat, or take comfort breaks had taken place. The department used intentional rounding and this was documented in records.
- Records were stored securely and accessible only to appropriate people.
- None of the staff groups were meeting the trust standard of 95% for information governance training. For example, reception (80%), administrative and clerical staff (60%), additional clinical services staff (66%), medical (75%) and nursing (56%) had all failed to reach this target.
- The trust sent us examples of spot checks carried out on clinical records to ensure that care plans, and treatment pathways were being followed. These showed that although compliance was good, there was room for improvement as compliance was not always 100% and there were occasional gaps in the information recorded.
- We looked at the standard of other records kept in the department such as cleaning logs, medication fridge checks and resuscitation trolley checks. We found that these were consistently completed.

Safeguarding

- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. These provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated theoretical knowledge.
- The trust had two paediatric liaison nurses, former health visitors, who checked over the records of children who had been through the department on a daily basis. The purpose of this was twofold; to ensure that any relevant other organisations such as GPs, school nurses or health visitors had been informed if necessary and to make sure that no vulnerable children, or incidents had been missed.
- We saw evidence that referrals for vulnerable adults and children were regularly made and information sent to health visitors about children who attended the department.
- The record system in the department routinely showed how many times a child had attended the trust ED services in the last 12 months and also in their lifetime. It also had alerts on screen to make staff aware of any special circumstances, needs or concerns relating to the patient.
- Safeguarding training included specific training about child sexual exploitation, people trafficking and female genital mutilation (FGM).
- The department was not meeting the trust standard of 85% compliance for safeguarding adults or children training. However, administrative staff were 100% compliant with level one children and level one adults.
- Training figures showed as follows: Safeguarding adults level two, 80% compliant for nursing staff and 38% compliant for medical and dental staff. Safeguarding children level one, 75% compliant for medical staff and 84% compliant for nursing staff level two, 80% compliant for nursing staff and level three, 56% compliant for medical staff and 89% compliant for nursing staff. At our last inspection we identified that training levels were low and informed the department that they must improve and meet the trust standard of 95%.

Mandatory training

- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%.
- Staff told us they could access some mandatory training via the intranet. They reported few problems accessing e-learning other than the occasional shortage of free time or computers.
- Staff told us it was not always easy to attend classroom based training due to staffing pressures on the ward.
- Training compliance levels for mandatory and statutory training varied. All staff groups were meeting the trust 95% standard for diversity awareness and mental capacity act awareness level one.
- Medical staff were failing to meet the standard for; conflict resolution (80%),consent (57%), health and safety (67%), infection control (63%), manual handling (81%), medicine management (29%), patient safety (53%), resuscitation training (73%) and fire safety (56%).
- None of the staff groups were fully meeting the targets for mandatory training.
- Nursing staff were failing to meet the standard for; health and safety (72%), infection control (88%), manual handling (93%), medicines management (77%), mental capacity level 2 (85%) and level 3 (80%), patient safety (58%), resuscitation training (59%), fire safety (58%), information governance (56%).
- Most notably, none of the staff groups were meeting the target for resuscitation training. Medical staff were at 73% and nursing staff were at 59%. This meant that not all staff were up to date with their resuscitation training.

Assessing and responding to patient risk

- Pontefract hospital had strict criteria for accepting patients by ambulance. This meant that the department received a low number of patients via ambulance. Patients who were more unwell were taken to either Pinderfields Hospital or Dewsbury and District Hospital.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust breached the standard in five of the 12 months between January 2016 and December 2016. After breaches in February and March, the trust met the target between April and September. However, the trust breached the target again between October and December. During

the whole nine months from April to December 2016 there was a deteriorating trend in performance. In December 2016, the trust's median time to treatment was 70 minutes compared to the overall average England figure of 60 minutes.

- The trust median time from arrival to initial assessment was consistently worse than the overall England median between January 2016 and December 2016. Between March and April 2016 the trust more than halved its median time from 27 minutes down to 13 minutes. However, this improvement was not sustained and performance deteriorated thereafter. Performance over time followed the same general pattern as for median time to initial assessment: an improvement in April followed by deterioration from then until December. Between October and December 2016, the median time to initial assessment was 23 minutes each month. This was worse than the average overall England figure of seven minutes in each of these three months.
- Between March and October 2016, there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes, from 54.3% in March to 61.1% in October. This was followed by an improvement between October 2016 and February 2017.
- In January 2017, 49.3% of ambulance journeys had turnaround times over 30 minutes; in February the figure was 45.9%. However, there was then a sustained improvement beginning from November 2016 rather than a continuing deterioration..
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between March 2016 and February 2017 the trust reported 1,670 "black breaches". The highest monthly totals were in October 2016 (333), June 2016 (193) and March 2016 (191). Between October 2016 and February 2017 there was a considerable reduction. February 2017 saw the lowest monthly total over these 12 months with 19 breaches. Pontefract had no black breaches.
- The trust's scored "better than" other trusts for one of the five A&E survey questions relevant to safety, "From the time you first arrived at the A&E Department, how long did you wait before being examined by a doctor or nurse".
- The trust scored "about the same" as other trusts for the remaining four questions.
- The department used the Manchester triage system for assessing the level of urgency to be seen by a doctor.
- Patients were triaged on attending the department and staff based their decisions about whether the patient should be treated in the minors or majors area.
- We discussed triage with the sister. They told us that any member of staff could triage as long as they had completed eight hours of supervised triage before being able to triage alone. This included newly qualified nurses, nurses new to emergency care medicine and nurses new to the trust. We had some concerns that triage training was not robust and varied from site to site within the trust. There was no consistency in triage training of new staff across the trust.
- Patients with allergies wore a red wristband to ensure that they were easily identifiable.
- Staff recorded known patient allergies in patient records. All seven records we looked at had patient allergies recorded.
- The department used the National Early Warning Score (NEWS) to assist in monitoring patients and identifying when a patient's condition was deteriorating. Staff were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. In some cases, patients who deteriorated needed to be transferred to the Pinderfields Accident and Emergency Department. There was standard operating procedure in place when this needed to happen.
- During our inspection, we noted that all patients in the department had been prescribed hourly observations. However, we saw that one patient's heart rate had significantly increased but the frequency of observations had not been increased and the NEWS score not amended in recognition of the deterioration of the patient.
- We also saw that a patient who was "actively suicidal" had no documented observations, mental health checklist and no patient description written in their records in case they chose to abscond. Additionally, the patient was sat in a room close to the exit and out of view of staff. We had concerns about the way the department had responded to these risks.
- We observed another patient with a history of seizures placed in a side cubicle away from the direct sight of staff despite other more visible cubicles being available.
- There was emergency medical equipment in the department and staff were experienced at dealing with sick patients. There were senior staff on hand to support

less experienced staff until midnight. However after this time, there were no consultant staff on site, only GPs and an emergency nurse practitioner (ENP). Deteriorating patients were transferred by ambulance to one of the other EDs within the trust.

Nursing staffing

- As at February 2017, the trust reported that Pontefract ED had a vacancy rate of 10.1% for nursing staff.
- The nursing staff turnover rate was 13% for nursing staff as at February 2017.
- The nursing sickness rate in the department was 4.8%.
- The department used bank nurses and agency staff to cover gaps in the nursing rota. The priority was to use bank staff as these were usually regular staff working additional shifts. Information sent to us by the trust showed that Pontefract ED had used no agency nurses between March 2016 and February 2017.
- The trust had carried out an assessment of staffing levels for the department in March 2016 to ensure that the correct number of staff with the appropriate skills and experience were on duty. Staffing levels were based on the assessment.
- Planned and actual staffing levels were displayed in the department and updated on a daily basis.
- The department had no registered children's nurses despite the department seeing children. Additionally, the ENPs who worked in the department could only treat patients over three years of age. The department was not meeting the Royal College of Nursing guidelines which stated that there should be 24 hour children's nurse presence in the department.
- We asked how many nursing staff had undergone advanced paediatric life support (APLS) training or equivalent as required by the 2012 intercollegiate standards. We were informed that only two staff had done APLS training and these were now out of date.
- We were informed that the trust supported staff to have paediatric intermediate life support (PILS) training. Training information showed that 59% of nursing staff had completed their annual resuscitation training. However it was unclear what level of training this was. Additionally, 61% of nursing staff had completed their three yearly resuscitation. It was again unclear what level of resuscitation training this represented.
- Staff told us that nurses from ED were often asked to cover staff shortages on other wards or other sites. Both nursing and medical staff raised concerns about this practice as it had made staff reluctant to cover extra shifts in ED since they were not guaranteed to be working in ED.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses.
- The management team told us about the action the department was taking to recruit new staff to the EDs across the trust.
- There was an induction process in place and before agency staff were allocated to the department, they had to provide evidence of competency. The senior nurse in charge had to sign to say they were happy with the competencies of any bank or agency staff used.
- We observed a board round between nurses and saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues. We discussed handovers with staff. They told us that handovers were effective. Pontefract had a small team of staff on duty therefore it was easy to ensure that all staff were up to date with the relevant information relating to patients.
- We looked at the staffing levels for April 2017. There were seven days when actual registered nurse staffing levels were not meeting planned staffing levels. There were two night shifts when actual staffing levels fell below planned staffing levels. On one day shift and one night shift, there was only 50% actual staffing compared to planned staffing levels.
- There were eight days when health care assistant (HCA) twilight shift actual staffing levels were not meeting planned staffing levels. There were four occasions when there was no twilight shift HCA cover at all.
- The above figures did not take in to account when staff were moved from the department to cover shifts on wards or one of the other EDs. Therefore, even when the actual and planned figures matched, there was a risk that the actual staffing level would reduce as staff were sent to cover other wards.

Medical staffing

- Doctors staffed the department 24 hours per day seven days a week. However, after midnight, medical cover

was provided by GPs with telephone support from the ED consultant at Pinderfields. Consultant presence was between 8am and 5pm with middle grade cover until midnight.

- The trust had funding for 10 WTE consultants. At the time of inspection, there was a vacancy rate of 33%. There were seven WTE consultants employed in the department. Consultant sickness was low at less than 1% and turnover was at 20% (1.4WTE).
- Across the department there was a vacancy rate of 16% (4.05 WTE) and a sickness rate of 2.2%.
- When we spoke with staff, they told us that there were three consultant vacancies. These were covered either by existing staff or locums.
- The department used medical locums to fill gaps in rotas. Information provided to us by the trust was not split by site. From April 2016 to March 2017, locum shifts varied from 565 in December 2016 and 762 in March 2017.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- The trust reported to us that medical staff were fully up to date with revalidation requirements.

Major incident awareness and training

- The trust had a major incident plan that clearly defined the roles of each ED site within the trust.
- The Chair of the Regional Resilience Forum worked in the trust. They provided evidence as to the roles and responsibilities of the staff and the trust in the event of a major incident at either local, regional or national level.
- Staff could explain their roles in the event a major incident.
- There were documents which covered roles and responsibilities including internal resilience and wider support for the region or nationally.
- There was evidence staff were trained and that some had recently taken part in a regional major incident training exercise in Sheffield.
- Staff were able to evidence awareness of the trust's business continuity plan.
- The business continuity plan had been tested during our inspection when the electronic records system temporarily ceased to function. Staff were immediately able to put contingency plans in place which did not adversely affect the service or patient safety

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as 'requires improvement' because:

- The department was not taking part in national or local audits such as the departmental sepsis audit. This meant that there were no checks in place to make sure patients were receiving care in line with Royal College of Emergency Medicine (RCEM) standards and guidelines.
- Staff had not recorded pain scores in the records we looked at, despite five of seven patients having suffered a limb injury.
- The rate of nursing staff appraisal did not meet the trust standard.
- Although the department was open 24 hours per day, services were reduced overnight and CT diagnostic imaging was not available overnight.
- Although staff understood the principles of the mental capacity assessments they were unclear about best interest assessments and deprivation of liberty safeguards.
- There was an unreliable on site blood diagnostic service. This was because the machine frequently broke down.

However:

- There was evidence of good multi-disciplinary team (MDT) and multi-agency working with a number of different teams attending the department to see patients with conditions such as dementia, mental health needs, substance misuse or requiring a bed on a ward.
- There was an electronic system in place to enable staff to access guidelines and pathways. These were up to date and evidence based. Staff had ready access to information relating to patients.
- Patients could access drinks and snacks in the department.

Evidence-based care and treatment

- Departmental policies were based upon NICE (National Institute for Health and Clinical Excellence) and Royal College guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.
- The department used a resource called CEM Books. This could be accessed online or using a phone application. It meant that staff had instant access to the most up to date guidance available. We carried out a random check of ten guidelines and found all were in date, had an identified responsible author and a review date.
- There was a wide range of departmental policies and guidelines for the treatment of both children and adults. Staff knew to access these online using CEM Books.
- We saw evidence that the department had pathways for a number of conditions such as sepsis and head injury for both adults and children.
- At our last inspection, we identified that this department was not taking part in trust-wide sepsis audits. At this inspection, we found this was still the case. We were told it was because the department did not see many sepsis patients. However, we had concerns that low numbers should not be seen as low risk. The department had no assurance that sepsis patients who attended Pontefract hospital were receiving care in line with the sepsis pathway.
- We discussed whether staff took part in any clinical audit activity at Pontefract and staff told us that they were unaware of any clinical audit activity.
- The trust's audit plan showed that there were departmental and cross departmental audits being carried out however it was unclear whether Pontefract were included in these plans.
- We had concerns that the department at Pontefract had no mechanisms in place to ensure that the care and treatment they were delivering was meeting national guidelines or standards.

Pain relief

- We looked at the records of seven patients who had attended the department. Of these, five had upper or lower limb injuries. None of the patients had a pain score recorded. One patient had received analgesia.
- At the time of the inspection, the department was quiet so we were unable to ask any patients whether they had been offered pain relief.
- Some staff such as ENPs used PGDs. The PGDs we looked at were all in date.
- The CQC's national 'A&E survey 2014' showed that the trust performed "about the same" as other similar trusts for the time patients waited to receive pain medication after requesting it.
- In the same survey, the trust performed "about the same" as other similar trusts when patients were asked whether staff did everything they could to control people's pain.

Nutrition and hydration

- Staff told us that sandwiches and beverages were available to patients. We overheard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks.
- There was a vending machine and water fountains available for patients and relatives to use.
- None of the patients in the department needed fluid balance charts. This was the same for the patients whose records we looked at. Staff told us that if required, fluid balance charts were used.
- We spoke with two patients who confirmed they had been offered a drink and informed of the location of the water fountain.
- In the CQC A&E Survey, the trust scored 7.3/10 for the question, "Were you able to get suitable food or drinks when you were in the A&E department?" This was "about the same" as other trusts.

Patient outcomes

- Between February 2016 and January 2017, the trust's unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. Performance was worse than the overall England performance in the period. In December 2016, trust performance was 8.7% compared to the overall England performance of 9.2%.
- The department at Pontefract did not take part in any of the RCEM (Royal College of Emergency Medicine) audits.

Competent staff

- According to information provided by the trust, as at 1 March 2017, 47% of nursing staff and 100% of additional clinical services staff had undergone an appraisal within the last 12 months.
- Staff felt able to discuss clinical issues and seek advice from colleagues and managers.

- Recently appointed staff were supported by colleagues. Newly qualified staff had preceptorship in place to support them to gain their competencies.
- The department employed emergency nurse practitioners and advanced nurse practitioners to work predominantly in the minors department to treat minor injuries.
- The department used a triage system to assess the urgency of need of patients attending the department. There was no single training process across the trust to make sure that staff were competent to carry out triage. Each site trained and assessed staff competency differently and each had different minimum standards before a staff member was eligible to triage.
- Senior members of staff informally monitored staff competencies throughout the year as well as through appraisal. This was only recorded if concerns were identified.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Multidisciplinary working

- The Emergency Department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department and the assessment suite.
- There was good access to psychiatry clinicians within the department with 24 hour telephone access to psychiatric liaison staff.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- The trust had an admission avoidance team who worked to support staff and patients to access alternative services in the community and avoid admission to wards. Any patients who required admission were transferred to one of the alternative hospitals in the trust as soon as a bed was available.

Seven-day services

- The ED offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants based at one of the other sites throughout the 24 hour period.
- The department was staffed by an emergency nurse practitioner, staff nurse, health care assistant and GPs overnight.
- There was 24 hour, seven day access to diagnostic blood tests however the onsite system was not reliable and regularly broke down.
- Radiology tests such as x-rays were carried out as and when needed however there was no 24 hour access to a CT scanner. Any patient needing an urgent CT was transferred to another site.

Access to information

- Staff were able to access patient information using an electronic system and paper records. This included information such as previous clinic letters, test results and x-rays.
- Patients transferred to other services or sites took copies of their medical records with them.
- Clinical guidelines and policies were available on the trust intranet and via a phone application called CEM Books.
- During the inspection we saw that TV screens were present to display waiting times in the waiting area. Patients could see how many patients were in the department, the length of wait for the next patient to see a doctor and the likely total waiting time in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- A member of staff gave us an example of when they had used a Deprivation of Liberty order to prevent a patient leaving the department. In practical terms, the senior nursing and clinical staff had made a best interest decision to prevent a vulnerable and at risk patient from leaving the department rather than using Deprivation of Liberty. The team had sought advice from the safeguarding team to ensure that the process was fully documented appropriately.

Urgent and emergency services

- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they adopted implied consent when the patient agreed to a procedure. We saw evidence of staff explaining procedures to patients and patients agreeing to them.
- Staff working in the children's area were aware of Fraser guidelines relating to decisions made by children and young people.
- Mental Capacity Act and consent training was part of safeguarding adults training.

Are urgent and emergency services caring?

Good

We rated caring as 'good' because:

- Staff ensured that the privacy and dignity of patients and their families was maintained.
- Patients and their relatives were given information about care and treatment and kept informed about tests and planned treatment.
- The department performed better than the England average in the friends and family test with an improving trend.
- Patients told us the staff were kind, caring and helpful. They answered questions in language that patients could understand.
- Pastoral support was available for patients and families of any or no religious belief.

Compassionate care

- During our inspection we spoke with three patients who were happy with the care they received.
- Patients described to us how staff treated them with dignity and respect.
- Results from the 2014 A&E survey showed that the trust scored about the same as other similar trusts when patients were asked if they felt they were treated with respect and dignity in the department.
- When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel as though they were being well cared for.
- In the patient led assessment of the care environment survey undertaken in April 2016, Pontefract Hospital scored 80% for privacy, dignity and wellbeing. There were no figures specifically for the Emergency Department.
- The trust performed about the same as other trusts in 22 of the 24 compassionate care questions in the '2014 Accident and Emergency survey'.
- The friends and family test showed that between February 2016 and January 2017, the department performed better than the England average for percentage of patients recommending the department to friends or family. The national average was around 87%. There was a trend of improvement over this time.

Understanding and involvement of patients and those close to them

- Results of the 2014 A&E survey showed that the department performed better than similar trusts in one questions, "Did a member of staff explain the results of the tests in a way you could understand?". The trust score worse than other trusts for the question, "Were you told how long you would have to wait to be examined?".
- During our inspection we heard a junior doctor speaking with a young person and their parent neither of whom spoke English as a first language. The doctor gave information to the family in language that was clear and easy to understand. They took time to make sure the family understood fully and gave them time to ask any questions.

Emotional support

- Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them. However, they sometimes found this difficult when the department was busy, due to staffing levels.
- We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.
- Staff offered support and gave information about support services if this was required.
- Staff could refer patients who presented with alcohol or drug problems (regardless of their age) to support services available via the alcohol liaison nurse.
- There was pastoral support available for patients of any or no religious belief.

Urgent and emergency services

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

Requires improvement

We rated responsive as 'requires improvement' because:

- The department had no specific room, equipped to support mental health patients.
- There was no written information for patients who required information in alternative formats such as other languages or Braille.
- The department only accepted ambulance patients who met strict criteria by prior arrangement.
- The department provided a reduced service overnight due to the staff on duty and both night and day, some patients had lengthy waits to be transferred to other hospitals to receive the most appropriate treatment.

However:

- The department was equipped to deal with the individual physical needs of patients. Bariatric and other special equipment was available either within the department or on site from other departments
- Patients whose first language was not English could access telephone interpreters.
- The department worked with a charity to support patients to be discharged home when this was appropriate.
- The department was performing only slightly worse than the four hour wait indicator with 94.5%
- The department used GPs at certain times of the day to deal with minor illnesses and injuries to ease the pressure within the department.

Service planning and delivery to meet the needs of local people

- The trust had three EDs and was in the process of reviewing how to best make use of each site and the resources they had most effectively.
- Pontefract hospital ED overnight services were provided by an Emergency Nurse Practitioner and one GP with an ED background. The GP saw patients under one year old who had minor illnesses and injuries. Patients with serious conditions could only be stabilised before being transferred to one of the larger sites.
- At the time of the inspection, as part of the reconfiguration programme, Pontefract hospital only accepted ambulance patients who met specific criteria. Patients who did not meet the criteria were taken to other EDs.
- Young children and sick patients who self-presented were stabilised and transferred to the most appropriate ED at either Dewsbury and District Hospital or Pinderfields Hospital. This sometimes led to long waits for patients due to delays in the availability of transfer ambulances.
- Managers were aware of the type of patients who attended the department and the potential incidents which could occur locally and had ensured that the department had the necessary equipment and trained staff to manage such situations.
- The department had acknowledged the mental health needs of the local population and had access to mental health services.
- The department worked with a charity to support vulnerable patients to be discharged home rather than admitted when appropriate.

Meeting people's individual needs

- The trust scored "about the same" as other trusts for all three A&E Survey questions relevant to the responsive domain.
- The waiting room was able to accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available.
- There was equipment available, such as beds and wheelchairs, for bariatric patients either in the department or around the trust for loan.
- There were vending machines present in the department that relatives and carers could access and the hospital had shops and places to eat.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that, in an emergency situation, they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. The trust could also access telephone interpreters if necessary. We noted leaflets were in English and did not offer a choice of other languages, large print or braille.

- The department had access to sign language interpreters for people living with hearing impairment.
- There were private areas for relatives to wait whilst patients were being treated and there was a relatives' room close to the department.
- When a patient passed away, whenever possible, they were moved to a side room so that family could have privacy to visit.
- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs.
- Staff told us that whenever possible, people with dementia or a learning disability were seen as quickly as possible in order to minimise distress for the patient.
- Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.
- At the time of our inspection, the TV screens in the waiting room were not working. This meant that there was no visual information for patients about waiting times. Waiting times were only communicated to patients verbally if patients asked how long they would have to wait. However, the trust usually displayed information about the current longest wait to see a doctor, the number of patients currently waiting to see a doctor or nurse and the total number of patients in the department. This information was also easily accessible from the hospital website.
- For patients and relatives of all faiths or none there was access to chaplaincy services.
- Patients with purely mental health needs waited either in the relatives' room or a quiet cubicle until the CRISIS team came. However, on the day of our inspection we saw a patient with mental health support needs situated in a room next to the exit where staff could not see them.
- The trust had access to the psychiatric liaison team by telephone. Staff told us that this team was very quick to respond however when patients were referred on to the CRISIS team for further mental health support, long delays occurred meaning patients had to wait in the department.

Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival at the department. The trust consistently missed the standard between February 2016 and January 2017. Performance was also consistently worse than the overall England average performance. However, on this site, the average across the year fell only slightly short of the standard at 94.5%. In some months, the department was seeing more than 97% of patients within four hours.
- Between February 2016 and January 2017, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was consistently worse than the England average, with periods of large variance between the England average and trust performance. The trust's trends followed the England average, an improvement in April 2016 was followed by a trend of decline until January 2017. In April 2016, performance was 24.9%; in January 2017, it was 50.0%. The trust provided us with site specific inforamtion for June 2017. This showed 17% of patients on the Pontefract site waited more that four hours on a trolley once a decision to admit had been made.
- Over the 12 months, seven patients within the trust waited more than 12 hours on a trolley from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in February 2016 (five), June 2016 (one) and January 2017 (one). There was no information specific to this site available.
- The median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was worse than the overall England performance in 11 of the 12 months between February and January 2017 (May 2016 was the exception). Performance followed the same pattern as four hour target performance and the percentage of patients waiting between four and 12 hours from the decision to admit until admission. Following an improvement in April 2016, performance deteriorated between May (3.2%) and December 2016 (5.0%). For comparison in the latter month the overall England performance was 3.5%. This information was not available for each individual site.
- The trust's monthly median total time in A&E for all patients was better than the overall England performance in eight of the 12 months between January

and December 2016. Performance against this metric followed the same pattern as many of the metrics above: an improvement in April 2016 was followed by a deteriorating trend from then until December 2016. In April 2016, the median time was 133 minutes; by December it had increased to 160 minutes. There was no information available specific for this site.

- From our observations and discussions with patients and staff, patients were triaged and assessed quickly.
- The department used GPs at certain times of the day to deal with minor illnesses and injuries to ease the pressure within the department. This also helped ensure that patients were seen by the most appropriate person to treat them.

Learning from complaints and concerns

- Patients and relatives we spoke with were aware of how to make a complaint to the trust, although none of the people we spoke with had made a complaint about the department.
- There was information about how to raise concerns about the department or the trust as a whole on display in the department and there were leaflets available for patients to take away with them.
- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- Between March 2016 and February 2017, the trust received 18 complaints about the Emergency Department.
- The two most common causes for complaint were missed fracture and missed diagnosis. One complaint was graded as high and was being fully investigated, 14 were graded as medium and three were graded as low risk.
- Of the complaints made, the trust upheld five, partially upheld seven and did not uphold six. The complaint graded as high was upheld.
- Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff.
- Where applicable, the department generated action plans in response to complaints. These were allocated to specific individuals who took responsibility for completing the actions identified.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as 'requires improvement' because:

- Many of the issues we identified at our last inspection remained concerns at this inspection. For example, unreliable blood testing services, long waits for transfer to other sites and lack of clinical audit, including participation in RCEM audits and the trust wide sepsis audit.
- Staff at Pontefract had some concerns about the future of the department and felt that information about their future was not freely communicated unless they asked.
- Staff at Pontefract felt that although local management was very supportive, Pontefract hospital was often the forgotten hospital site within the trust.
- The new executive leadership team still had work to do to make the staff at Pontefract felt like an important part of the overall trust.
- The ED at Pontefract did not carry out clinical audit or specific patient engagement and therefore there were no systems in place to ensure that the quality of care delivered to patients was adhering to national standards.

However:

- There was a vision and strategy for the trust, including the reconfiguration of service provision across the three sites.
- Staff reported that the trust culture had improved greatly. They felt the trust was more open and inclusive of staff and they could openly voice concerns without fear of repercussions from the highest management levels.
- There were governance processes in place to ensure that performance was monitored and managed. There was joint working with the other EDs within the trust including governance and sharing lessons learned. Some of these were new and were yet to be embedded in to routine practice.
- The department had implemented some innovations to manage demand, enable better cross site communication and improve staff engagement.

Leadership of service

Urgent and emergency services

- The ED departments across the trust were led by a clinical lead, matrons and a business manager. Each site had their own matron. We met with the clinical, nursing and business managers as part of our inspection. The team appeared to work well together to provide a cohesive management team.
- Nursing staff told us that they felt well-led at a local level and they had no concerns with their line managers. They felt they could raise concerns and be confident they would be resolved whenever possible in a timely manner. They told us the management team was open, approachable and provided good leadership.
- Staff told us they felt as though Pontefract was often forgotten about and that although senior managers visited the site, this did not happen very often.
- Staff were aware of the trust wide reconfiguration of services however, they were unclear about the impact this would have on the department in Pontefract. Staff were concerned the department would be downgraded. They told us they had not been given much information from managers about what was going to change at Pontefract. Staff felt leadership at a higher level needed to be more visible and more communicative about the future.

Vision and strategy for this service

- The trust had a vision for the service and was working with local providers and commissioners to ensure that services met the needs of the local populations.
- Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand.
- Urgent and emergency care services were in the process of being reconfigured across the three ED sites within the trust. The reconfiguration of services meant that the future function of the department may change. Staff told us this was still to be decided.
- The trust sent us information about their plans for developing services to deal with changes in the demand of the public on urgent and emergency care. This included developing new roles, working with primary care practitioners, implementing new procedures in to the department to ensure it worked efficiently and effectively.

Governance, risk management and quality measurement

- At our last inspection we had some concerns about the clinical governance structure in place. This was because there was poor interdepartmental learning, particularly between Dewsbury and Pontefract. At this inspection we found there was a clinical governance structure in place involving all three sites. The trust had implemented a cross site clinical governance committee that staff could access via teleconference facilities if they could not attend in person. The meeting was introduced in January 2017 and was therefore quite new. However, staff we spoke with were very supportive of this development.
- Staff were invited to attend clinical governance, patient safety and clinical audit meetings.
- There was a process in place to ensure all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes.
- The staff we spoke with were clear about the risks the department faced. The introduction of CEM books meant shift leaders entered regular 'sitreps', in other words, information about the current situation in the department such as number of patients waiting to be seen, number of patients currently receiving treatment, staffing levels and bed needs. This supported managers with planning and also made sure that any risks or capacity concerns were logged and escalated appropriately.
- There was a process in place for ensuring the results of radiology investigations were followed up to ensure any "missed abnormality" was followed up in a timely manner. Where abnormalities had been missed, staff involved were informed and offered support and training to ensure the risk of future errors was minimised.
- A trust wide departmental risk register was available and was under regular review to ensure the content of the register was reflective of the real-time risks within the department. These risks correlated with the risks we observed during our time in the department.
- When we spoke with the senior management team, they were able to clearly tell us about the risks posed to the department and how these were being addressed.
- Managers discussed waiting time breaches regularly to identify any themes and were able to take actions to address issues, such as bed shortages across the trust.

- At our last inspection we noted that the department didn't take part in clinical audit activity. At this inspection we found that this was still the case.

Culture within the service

- We spoke with a number of staff from different disciplines about the culture of the department. We received a consistent message about the department. Staff said that colleagues were supportive of each other, cross discipline and across seniority. They described the department as friendly and like one big family.
- The atmosphere in the department showed that staff focus was on treating patients in an efficient way.
- The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked as a team to ensure patients received good care.
- Staff felt that their hard work was recognised and they felt appreciated by colleagues and line managers but that this was not always the case with senior management who did not work in the department.

Public engagement

- The department participated in the Friends and Family Test and CQC surveys but had not carried out any local surveys in relation to the quality of urgent and emergency care services.
- The trust had worked with the local Health Watch to determine why people attended A&E when they couldn't get a GP appointment. The results were shared with the local clinical commissioning group.

Staff engagement

- The three EDs had a closed social media page, which had approximately 300 staff members. Staff were able to share information, concerns and discuss events in the departments. Senior staff were able to see the issues within departments and monitor concerns and problems discussed by staff however, the page was not formally monitored. Senior staff were able to make sure there were no problems with morale and take action if anything caused them concern.
- Staff from the department had taken part in trust wide engagement exercises such as online surveys however there had been no specific engagement work carried out with the department.
- Staff told us they were kept informed about opportunities to personally progress.

Innovation, improvement and sustainability

- The trust had introduced a number of new initiatives to enable them to manage demand and work towards achieving the government set indicators.
- Patient waiting times, number of patients in the department and number of patients waiting to be seen by a doctor were displayed in the department waiting rooms and also on the trust's website.
- The trust's website was linked to Google translate so that people whose first language was not English, or who could not read English were able to read the website after a few clicks of a button. Although the translation was inaccurate in places it would support patients to find basic information.
- The department had introduced a video link across sites to enable staff to communicate effectively and attend meetings without having to take in to consideration travel times.
- The trust had a closed social media profile for staff to share information, celebrate success or share learning.

Surgery

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

Information about the service

Pontefract Hospital provided elective and day case surgery for colorectal, ENT (ear, nose and throat), ophthalmic, oral and maxillofacial, orthopaedic, urology, general and vascular surgery.

During this inspection we visited the day surgery unit, the elective orthopaedic suite and theatres on site and observed care given and surgical procedures undertaken.

We spoke with 12 patients and relatives and 15 members of staff. We observed care and treatment and looked at eight care records.

Summary of findings

The overall surgery rating from the 2015 inspection was 'requires improvement'. Actions the trust were told they must take were:

- Ensure there were systems in place to identify themes from incidents and near miss events.
- Ensure all theatres were monitoring compliance with the five steps to safer surgery.
- Ensure all staff understood the process for raising safeguarding referrals (in the absence of the safeguarding lead).
- Reduce and improve readmission rates.
- Ensure there were clear risk assessments in place for situations where practice deviates from the guidance.
- Continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

During this inspection we rated surgical services at this hospital as 'good' because:

- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels and staffing guidelines with clear escalation procedures were in place.
- The proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Surgery

- Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
- We saw evidence that Root Cause Analysis (RCA) and investigations of serious incidents were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
- We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- The Friends and Family Test (FFT) response rate for the hospital was better than the England average (29%) of patients who would recommend the hospital was higher than across the division.
- The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care.
- The division completed network meetings which were also held with neighbouring trusts from Sheffield, Huddersfield and Leeds for hip and knee replacements, upper limb and foot and ankle work.
- A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity.
- The trust had developed a joint 'Planned Care Group' with the Clinical Commissioning Group (CCG), with work streams addressing referral to treatment times (RTT) issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- A trust-wide patient experience project plan had been developed which looked at elements of patient care.
- The division handled 97% of complaints within trust timescales (95% target).
- There were clear governance processes in place to monitor the service provided. A clear responsibility and accountability framework had been established. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.
- Leadership at each level was visible, staff had confidence in the leadership and staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.

However:

- Medical staff did not meet the trust 95% target for mandatory core training completion, this included safeguarding
- NEWS audits in March 2017 showed that 59% of observations are recorded as prescribed/indicated by the electronic system, down from 67% in the previous audit cycle. The key reason for reduced compliance was observations being overridden without a set of observations being undertaken at time of the override.
- There were 108 medicines related incidents recorded between March 2016 and February 2017 across the surgical division.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week, by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.
- The proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.
- Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
- Surgical site infections were lower than the national average.
- The division held regular emergency surgery and elective care business unit meetings where serious incidents (SIs) were discussed, investigations analysed, and changes to practice identified.
- We saw evidence that Root Cause Analyses (RCA) investigations of SIs were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
- We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.

However:

- Medical staff did not reach the 95% target for any of the trust's core training including safeguarding.
- Across the division, NEWS audits (March 2017) showed that 59% of observations were recorded which was worse than the 67% compliance rate in the previous audit.
- There were 108 medicines related incidents recorded between March 2016 and February 2017 across the surgical division.

Incidents

- In accordance with the 'Serious Incident Framework 2015', the trust reported five serious incidents (SIs) in surgery between March 2016 and February 2017, which met the reporting criteria set by NHS England.
- Of these, the most common type of incident reported, with two of the five incidents was 'Medical equipment/ devices/disposables incident meeting SI criteria'.
- We saw evidence that Root Cause Analyses (RCA) investigations of SIs were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
- Staff told us how they reported incidents through the electronic system and said learning was shared through ward meetings, safety huddles, team briefings, and handovers. Staff were fully supported and attended regular meetings where feedback and learning was encouraged.
- Matrons and ward sisters had an overview of every incident, complaint and concern and operated a system of response and feedback to patients and staff. Evidence of this was documented in minutes of clinical governance meetings.
- Duty of candour is a process of open and honest practice when something goes wrong. We saw that legal requirements were explicitly stated within trust policies, intranet guidance, and training.
- Staff were aware of the duty of candour regulations. There was e-learning and written paperwork for staff to follow. We saw evidence of duty of candour carried out and staff were able to identify action they would take.
- All relevant staff attended mortality and morbidity meetings in all specialities to review case notes with joint surgical and anaesthetic reviews and reflective practice. Specialties also discussed cases at governance half-day meetings.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- Between March 2016 and February 2017, the trust reported one incident, which was classified as a 'Surgical/invasive procedure' never event for surgery. There was evidence of trust wide learning recorded in minutes of surgery ward meetings, clinical governance minutes and directorate operational team meeting minutes.

Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information.
- Trust data showed that the surgical division reported 16 new pressure ulcers, seven falls with harm and eight new catheter urinary tract infections between February 2016 and February 2017. There had been no more than one fall per month in surgery and there had been no new catheter urinary tract infections since September 2016.
- There had been no category 3 or 4 pressure ulcers, falls that caused harm or catheter urinary tract infections reported within the surgical ward at the hospital in the last twelve months.
- Venous thromboembolism (VTE) screening audits showed assessment compliance was 98% (January 2017), above the target of 95%.

Cleanliness, infection control and hygiene

- The trust had policies in place for aseptic techniques, patient transfers, hand hygiene, clostridium difficile infection (C difficile), Methicillin-sensitive Staphylococcus aureus (MSSA) and methicillin resistant staphylococcus aureus (MRSA). These were available on the trust intranet.
- The division reported one incidence of MRSA and seven incidences of MSSA between March 2016 and February 2017. Nine cases of clostridium difficile (C. difficile) were reported in the same period. However, five of these cases were non-trust acquired. None of these were reported within the surgical ward at this hospital.
- Surgical site infection (SSI) at Pontefract General Hospital rates was zero for total hip replacements (April 2016).
- Infection control audits were completed each month and monitored compliance with key trust policies such as hand hygiene, 'bare below the elbow', catheter and cannula insertion and on-going care.
- Hand hygiene and 'bare below the elbow' targets (98% compliance) were met for all wards between March 2016 and February 2017.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas. These showed 100% compliance with clean commodes, hand hygiene, cannula and catheter audits.
- We observed staff washing their hands and all patients we spoke with confirmed this was done. Hand gel was available throughout the hospital and at the point of care. Staff used personal protective equipment (PPE) compliant with policy. Wards and surgical areas had daily, weekly and monthly cleaning schedule for domestic staff, housekeepers and nursing staff. We observed clean equipment and completed cleaning records throughout surgical areas.
- Clinical and domestic waste disposal and signage was good and we saw staff disposing of clinical waste appropriately. We observed staff compliance with trust policy for linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps.

Environment and equipment

- All wards and surgical areas were uncluttered and in a good state of repair. All surgical areas had storeroom capacity which was easily accessible and tidy.
- We inspected resuscitation trolleys, suction equipment on wards, and found all appropriately tested, clean, stocked and checked as determined by policy.
- We saw compliance with trust policy 'Portable Electrical Testing of Equipment' to fit a dated label of the test to the equipment tested.
- All managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips and falls. Risk assessments included types of hazard and likelihood of occurrence, quality and condition of flooring, maintenance and cleaning procedures.

- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2016). The results showed the surgical division scored 97.4% on the cleanliness and 94.7% for the condition of the environment.

Medicines

- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks. Audits were carried out by the wards and pharmacy.
- All medication was prescribed and administered in line with the trust policy and procedures. Pharmacists liaised with the ward team regularly. We found allergies clearly documented and records were correctly completed.
- Medicines requiring refrigeration were stored securely, with maximum and minimum temperatures recorded in accordance with national guidance. Staff had been trained in the use of the recently introduced automatic electronic recording system.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- There were 108 medicines related incidents recorded between March 2016 and February 2017 across the surgical division. These were reported through incident reporting procedures and resulted in increased training and learning for teams and individual members of staff.

Records

- We looked at eight sets of patient, medical and nursing records on the wards and theatres at the hospital. We saw they were complete, legible and organised consistently. Records were signed and dated, clearly stating named nurse and clinician.
- All records reviewed included a pain score and allergies documented in the notes.
- Patient notes were stored in lockable trolleys and patient care charts were kept at the bedside for ease of access to staff. We did not observe a breach in confidentiality during inspection.
- Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
- Daily entries of care and treatment plans were clearly documented and care plans had observation charts and evaluations, with consent forms and mental capacity assessments where necessary.
- We saw good examples of detailed and complete preoperative checklists and consent documentation in patient's notes.
- Theatre and anaesthetic notes in all post-operative files were comprehensive and detailed.
- We reviewed handover sheets used by ward staff and found documentation was effective in communication and decision making for those patients at risk of deterioration.

Safeguarding

- Safeguarding information was shared with the patient safety panel on a fortnightly basis with regular feedback received and disseminated to all teams trust wide. Safeguarding updates were discussed at ward rounds and safety huddles.
- We found that staff within the division understood their responsibilities and discussed safeguarding policies and procedures confidently and competently.
- Staff felt safeguarding processes were embedded throughout the trust. The trust advised that they had increased ward visibility of the safeguarding team to ensure access for support and assistance for staff.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.
- Within the division compliance rates for nursing staff mandatory training achieved the target for compliance (95%) for Safeguarding Adults Level 1 (96%) and Safeguarding Children Level 1 (96%). Data showed 81% of nursing staff had completed Safeguarding Adults Level 2 and 79% had completed Safeguarding Children Level 2. The division did not meet the compliance target for Safeguarding Children Level 3 (67%) – one member of staff had not completed training.
- Medical staff in the surgical core service did not reach the target for any of the safeguarding courses that staff were eligible.

Mandatory training

- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%.
- Mandatory training for nursing staff had met compliance targets across the division in manual handling, Mental Capacity Act (MCA) Level 1 and health and safety. The lowest compliance figures were for resuscitation training (77%) and fire safety (77%).
- At this hospital we were given data that showed compliance with mandatory and statutory training at 98% and that 85% of staff had received an appraisal within the last twelve months.
- Medical staff in the division did not reach the target (95%) for any of the trusts core training. Mandatory training for medical staff had not met compliance targets across the division in, for example, resuscitation training (45%), medicines management level 2 (65%), information governance (57%), and MCA Level 1 (90%)
- We interviewed managers within the division who outlined local and divisional plans to address low compliance rates with mandatory training. These involved identifying time and resources to encourage staff to address shortfalls in their training as well as identifying alternative ways to access training.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning and by face to face training. Although staff confirmed they were up to date with mandatory training, they felt this was being impacted by staff shortages.
- Staff said they were supported with professional development through education and revalidation and that they had robust induction, mentorship and preceptorship programmes.

Assessing and responding to patient risk

- The trust had recently introduced the NEWS risk assessment system for recognition and treatment of the deteriorating patient. NEWS audits in March 2017 showed that 59% of observations were recorded which was down from the previous audit (67%).
- The audit also showed that of those patients whose care was escalated, 86% of those patients had been escalated appropriately or had a plan in place.
- We saw that the completion of NEWS audits had been raised through meetings and communication books on wards. Ward managers told us they were talking to staff members on a team and individual basis to raise compliance with NEWS audits.
- The trust had been flagged as a mortality outlier for rates of septicaemia and aimed for screening of 90% of patients in the emergency departments and 98% of inpatients. Sepsis has been included in induction, mandatory training and continuous development for doctors and nurses and was promoted through handover.
- An extensive awareness campaign had been launched to advertise use of the new sepsis screening documentation in December 2016.
- A trust audit (November 2016) showed 97% compliance with the 'Five Steps to Safer Surgery' for the team brief before surgery. The audit also showed 91% 'time out' opportunities taken by all members of the theatre team to stop and listen to patient safety information. Debrief was recorded at 98% attendance rate.
- We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patients' nutritional needs. Pain scores and diaries for patients were available.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example one to one nurse patient ratio, close observation, safety rails on beds, falls stockings, symbols to identify risk on display boards and nurse call system in reach.
- Ward managers, matrons and managers in surgical wards and areas were available and visible and involved in supporting staff and addressing issues.
- Risk assessments, handover processes and safety briefs were observed and we saw all staff worked and communicated well as a team. We observed 'risk approach' handover sheets used by ward staff and escalation plans were effective in decision making for patients at risk of deteriorating.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- The division reported a nurse vacancy rate of 3.4% on inpatient wards and 9.4% for health care assistants. The vacancy rate within theatres was much higher at 25% for nurses and 25% for operating department assistants.
- The qualified and unqualified nurse vacancy rate at this hospital was 8% (February 2017). National and international campaigns were in place to address the recruitment gap.
- The division reported a qualified and unqualified nurse sickness rate of 5% (February 2017) at this hospital.
- Between March 2016 and February 2017, the division reported a bank usage rate of 12% in surgical care and 7% at this hospital.
- The average 'fill rate' was 90% for nursing staff and 100% for health care assistants. The trust had an established staff 'bank', which provided cover for short notice requests.
- The trust reported a turnover rate of 13% for all staff groups in the surgical division (February 2017) and 11% at this hospital.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours by senior nurses with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances. On the ward, actual staffing levels were in line with those planned. An advanced nurse practitioner was present on every shift.
- The division collected acuity data daily using an electronic application to identify how many patients are at specified levels of acuity. 'Red flags' indicated concerns such as falls and the inability to respond to patients due to staffing levels.
- Staffing levels were checked daily by a ward manager and supported by a matron. This information was recorded centrally, and helped inform decisions to support wards where staffing was depleted.
- Staffing reviews were carried out annually, based on data from available systems and on clinical judgement based on activity and demand. There was a process in place for reassessing staffing levels when services changed.
- The trust aimed to staff areas on a ratio of one qualified nurse to eight patients with a co-ordinator outside of these numbers. At the time of inspection the trust was moving towards "Care Hours per Patient Day" as a more informed methodology for providing care at peak times of demand.
- Although, most staff acknowledged the trust had tried to increase the effectiveness of recruitment and retention, they told us individuals had been working under extreme pressures for some time to cover shifts.
- Staff told us the processes in place to move staff to other wards and departments to ensure safe staffing levels caused anxiety over experience and suitability. During the inspection we saw medical 'outliers' on surgical wards, staff said this added to their workload and anxiety.

Surgical staffing

- In December 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.
- As at 28th of February 2017, the trust reported a vacancy rate of 8% in surgical care. The trust reported that a major recruitment programme was underway to address the gaps in consultant medical staffing.
- Over the same period, the division reported a turnover rate of 6% and a sickness rate of 1%.
- Locum usage in theatres between January 2017 and March 2017 was highest in anaesthetics with 981 shifts filled by locums across the trust. A further 921 shifts were covered by locum staff across the trust for all other specialities in the same period.
- Consultants and junior doctors were available for handovers, ward rounds and MDTs. Staff had good relationships with senior surgical doctors and consultants.
- Consultant led surgical handovers took place daily at the hospital in private areas to maintain confidentiality and systems and policies were in place for escalation of a deteriorating patient.

Major incident awareness and training

Surgery

- The trust had major incident and business continuity plans in place that included protocols that included deferring elective activity to prioritise unscheduled emergency procedures. Major incident plans were reviewed and updated annually.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response. There were business continuity plans for surgery and senior staff were able to explain these during interview.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.
- Potential risks were taken into account when planning services and consideration given at daily safety huddles regarding seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Action plans were discussed and implemented as necessary.
- The impact on safety when carrying out changes to the service and staff, was assessed and monitored through robust, embedded assessments, staff engagement and ongoing service monitoring.
- The trust had centralised acute surgery on the Pinderfields site and to comply with the NHS England Emergency Preparedness Resilience and Response (EPPR) Framework had undertaken a review of the service reconfiguration to ensure it was able to comply with its category one EPRR requirements under the Civil Contingencies Act.

Are surgery services effective?

Good

We rated effective as good because:

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- The surgical division prioritised 33 level one clinical audits covering a range of specialties. Outcomes from each audit were reported to the trust's quality panels and directorate operational team meetings.
- The trust undertook patient satisfaction surveys in relation to pain management which showed that overall patients were happy with their pain management and associated support, information and guidance.
- Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Regular audits were carried out to monitor performance against national patient outcomes and to maintain standards.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- Enhanced recovery pathways were used for patients and ensured patients were escorted through the care pathways and ensured each patient received continuing care, including preoperative assessments, perioperative admission and postoperative discharge and follow up.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- The surgery division took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- During the previous year the division prioritised 33 level one clinical audits covering a range of specialties. Outcomes from each audit were reported to the trust's quality panels and directorate operational team meetings.
- The Trust was not eligible for the National Vascular Registry (NVR) audit.

Pain relief

- Patients told us they were regularly asked about their pain levels, particularly immediately after surgery. We saw this was recorded in patient notes on a pain scoring tool that was used to assess patients' pain levels.
- Following an audit of pain management in the recovery room, the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief had been put in place.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the 'Friends and Family Test' and directly from patients.
- Staff asked patients regularly if they had any pain, so they could administer analgesia promptly.
- A pain link nurse had been identified and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.
- Each ward maintained good links with the pain management team. All patients we spoke with reported their pain management needs had been met.
- A dedicated pain team was accessible to educate staff on new equipment and medications. The pain team visited patients with PCAs the day after surgery. Anaesthetists provided support with pain relief as required.
- The trust undertook patient satisfaction surveys in relation to pain management. The trust reported that 129 surveys were completed (2016) and showed that patients were happy with their pain management and associated support, information and guidance.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients. Staff identified patients at risk of malnutrition by working with patients and their families to complete a Malnutrition Universal Screening Tool (MUST) score.
- Ward audits confirmed patients received a nutritional risk assessment on admission and a timely review. We saw appropriately completed fluid balance charts and dietary intake charts.
- The nutritional risk assessment identified the levels at which dietitian referral was recommended. The dietetics service received inpatient referrals and provided input as required. The division had protocols in place for enteral feeding out of hours ensuring patients did not have to wait.
- We saw a range of food choice, meals and snacks for patients who required nutritional support. Patients reported their meals to be good, with a hot breakfast, choice and staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients before and after surgical procedures.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether surgery was in the morning or afternoon.
- We reviewed eight records and saw nurses completed food charts for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic department.

Patient outcomes

- Between November 2015 and October 2016, patients at the trust had a lower than expected risk of readmission for non-elective admissions and a higher expected risk of readmission for elective admissions when compared to the England average.
- Of the top three specialties with the highest activity, General Surgery and Plastic Surgery both have relative risk of readmission higher than the England average for elective admissions.
- Pontefract General Hospital had a lower relative risk of readmission for elective admissions and a higher risk of readmission for non-elective admissions.
- The Bowel Cancer Audit (2016) showed that 81% (80% in 2015) of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than than the national aggregate.
- The risk-adjusted 90-day and two year post-operative mortality rates were within the expected ranges. The risk-adjusted 30-day unplanned readmission rate was 6.5% which falls within the expected range.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54% which falls within the expected range. The 2015 figure was 58.2%.
- In the Bowel Cancer Audit (2016), 81% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 80%.
- The risk-adjusted 90-day and two year post-operative mortality rates were within the expected ranges.
- The risk-adjusted 30-day unplanned readmission rate was 6.5%, which falls within the expected range.

- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54%, which falls within the expected range. The 2015 figure was 58.2%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 10.5%. This placed the trust within the middle 50% of all trusts for this measure.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.3%, significantly lower than the national average.
- This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level with better co-operation between hospitals within a network would be expected to produce better results.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2016 to March 2017, three indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Four indicators showed fewer patients' health improving and more patients' health worsening than the England averages, and four were in line with the England averages.

Competent staff

- The trust provided data that showed 73% of nursing staff appraisals had been completed against a target of 85% (February 2017). The completion rate of medical staff appraisals within the surgical division was 80% (target of 91%). Divisional action plans were in place to ensure compliance with trust targets.
- Staff told us that the appraisal process was effective and allowed them to discuss developmental and learning objectives agreed between staff and managers. Generic training needs were addressed through the trust and local induction as well as ongoing mandatory training sessions and updates.
- Support was provided for nursing revalidation by identifying expectations and the continued education required.
- Staff felt supported with their training and in maintaining competence. We found staff were encouraged to undertake additional learning when time allowed.
- Ward managers were clear during discussion that new members of staff were mentored and supported until they gained the necessary skills, knowledge and experience to do their job when they started their employment. A system had been developed to identify the experience level of staff through wearing different uniform badges. Experienced members of staff were gradually encouraged to take on additional role and responsibilities once it had deemed appropriate.
- Junior doctors 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.
- The division had developed surgical simulators in the trust education centre and a training programme director for regional registrar and junior doctors training had been identified to facilitate the 'Core Surgical Skills Course'.
- The trust will host the Fellowship of the Royal College of Surgeons (Trauma & Orthopaedic) exit examinations in 2018.

Multidisciplinary working

- Twice daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately. Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- We saw a multi-disciplinary approach to assessing, planning and delivering people's care and treatment. Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Staff advised that there were good working relationships with pharmacy staff at Pinderfields General Hospital and a medication shuttle service operated between the two sites. If needed, additional pharmacy support and advice was available.

- Staff explained to us they worked with local authority services as part of discharge planning. We saw that discharge planning commenced at pre-assessment.
- Protocols had been developed for the effective handover of patients when required. These involved the identification of bed availability, NEWS assessment and both verbal, and written transfer of information.
- Ward staff worked closely with the patient, their family, allied health professionals and the local authority when planning discharge of patients with complex needs to ensure the relevant care was in place and that discharge timings were appropriate.

Seven-day services

- A comprehensive transfer plan was in place for deteriorating patients to access emergency care within the trust seven days a week. Consultants were available at all hours on call and attended daily ward rounds over seven days to review new admissions and provide emergency patient care.
- There was access to a full range of diagnostic services across seven days to deliver high quality and efficient care to patients.
- During the inspection, we found that all surgical specialities had 24 hour consultant cover with seven day daytime cover in general surgery, urology, plastics and orthopaedics.
- All surgical wards planned to develop 'Keogh ward rounds' to improve seven day working. 'Keogh ward rounds' are consultant-delivered ward rounds providing a structured and consistent opportunity for the multidisciplinary team to review patients' progress, share information and communicate with the patient.
- There were dedicated physiotherapist and occupational therapists available Monday to Friday. There was limited access to physiotherapists and occupational therapist at the weekend and patients were prioritised by level of need.
- Pharmacy services were provided during weekdays from 9am to 5pm from the Pinderfields General Hospital site. An emergency drugs cupboard was available for access to medicines out of hours and an on call pharmacist was available for urgent advice and supplies when the pharmacies are closed.
- The elective orthopaedic service operated up to six days of the week. Elective admissions were planned based on consultant availability and complexity of procedures. The trust had plans in place to increase the service with daily extra theatre lists and by extending hours at the weekend.

Access to information

- We saw that risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.
- Surgical wards utilised an electronic observation monitoring system which allowed immediate access by any other clinician or professional providing care. The system was actively used on all surgical wards.
- We reviewed discharge arrangements and planning started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.
- All staff had access to policies, procedures and NICE guidelines on the trust intranet site. Staff we spoke to stated they were competent using the intranet to obtain information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The division had policies and procedures in place that ensured capacity assessments were completed and consent obtained. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. Patients also consented on the day of procedure.
- We looked at eight records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.
- The trust had policies in place to inform and guide practice around the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Information

and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.
- Staff we spoke with were confident in identifying issues about mental capacity and knew how to escalate concerns in accordance with trust guidance.
- MCA assessments were undertaken by the nurse or consultant responsible for the patient's care and DoLS were referred to the trust's safeguarding team. MCA and DoLS assessments were included in risk assessments.
- MCA and DoLS training was delivered as part of staff induction. The divisional completion rate for MCA and DoLS training was 89% at level two and 91% at level three for nursing staff. Medical staff completion rates for MCA level two was 60% and 84% for level three.
- There was access to an Independent Mental Capacity Advocate (IMCA) when best interest decision meetings were required.

Are surgery services caring?

Good

We rated caring as good because:

- The Friends and Family Test (FFT) response rate for the hospital was 55%, which was better than the England average (29%) and higher than the average for the division. The FFT results for patients who would recommend the trust was 97%.
- We observed compassionate treatment of patients which was delivered in a dignified and respectful way. All staff including ward managers were available on the wards to speak to relatives and patients.
- Patients and relatives were involved in their care and they had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained procedures and treatment.
- Care plans highlighted the assessment of patients' emotional, spiritual and mental health needs.
- Patients said they were happy with the care they received, that the staff were polite, helpful and that staff took the time to explain the surgical procedure and process.

Compassionate care

- The Friends and Family Test (FFT) response rate for the division was 31%, better than the England average of 29% (February 2016 to January 2017). At this hospital, the response rate was higher than the England average at 55%. The FFT results for patients who would recommend the trust was 97%.
- In the Cancer Patient Experience Survey 2015, the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for 11 questions.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2016). The results showed the surgical division scored 79% for providing privacy and dignity for patients and 66% for dementia care.
- Patients said that they were happy with the care they received, that the staff were polite, helpful and that staff took the time to explain the surgical procedure and process.
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- During inspection, we observed patients being spoken to in an appropriate manner, information being shared in a method that they understood and saw staff took the time to reassure and comfort patients.
- Staff spoke to patients as individuals and demonstrated knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.
- Patients told us staff responded promptly to the call bell system and that they asked about pain control. Pain relief was given as required.
- Staff understood and respected people's personal, cultural, social and religious needs, and considered these when delivering care and planning discharge. We observed staff take time to interact with patients and relatives in a respectful and considerate manner.
- Staff showed empathy and were supportive to people in their care. People's privacy and dignity was respected when assisting with physical or intimate care.
- Staff promoted independence and encouraged those in bed to take part in personal care, to mobilise within their limits and positively encourage those patients who were having difficulty.

Understanding and involvement of patients and those close to them

- Patients said staff took time to explain procedures, risks and possible outcomes of surgery and after care. Complex information was repeated more than once by different staff so that they understood their care, treatment and condition.
- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan and felt involved in their care. Regular ward rounds gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients and relatives felt involved in their care, due to regular ward rounds with consultants. Staff provided an opportunity to ask questions, and explained patients surgery and treatment.
- We saw that ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to take relatives or friends to the consultation.
- The trust offered a 'forget me not' passport of care for patients with dementia or learning difficulty. We saw this was completed by families and carers, telling the staff how to care for the person to meet their individual needs.
- The trust operated a befriending service across all wards. The befrienders provided social and emotional support, helped with drinks and nutrition, were able to refer to community services and assisted patients with information relating to their discharge home.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs.
- Care plans highlighted the assessment of patients emotional, spiritual and mental health needs. These care plans were complete in case notes observed on wards and surgical areas. The trust operated a policy of open visiting for friends, carers and family members.
- Psychiatric liaison and dementia support workers were employed by the trust and supported patients as necessary. The trust aimed to screen all patients admitted acutely over age 75 years for potential and actual dementia and delirium.
- All wards had identified link nurses specialising in dementia, learning disability and safeguarding.
- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.
- The trust's chaplaincy team provided a range of spiritual and holistic support, including regular visits to wards to meet with patients.
- The team acted as apoint of contact with the appropriate faith community, provided Christian and Muslim worship and prayers in the hospital chapels and prayer rooms, Holy Communion at the bedside and 24-hour on-call service including out-of-hours cover for emergencies via hospital switchboards.

Are surgery services responsive?

Good

We rated responsive as good because:

- The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care.
- The divisional business plan (2017/18 to 2018/19) supported the implementation of a comprehensive operational plan which delivers the trust strategic aims and links directly with capacity, workforce and financial plans.
- The division held network meetings with neighbouring trusts from Sheffield, Huddersfield and Leeds for hip and knee replacements, upper limb and foot and ankle work.
- A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity.
- The trust had developed a joint 'Planned Care Group' with the Clinical Commissioning Group (CCG), with work streams addressing RTT issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- A trust-wide patient experience plan project had been developed which looked at elements of patient care.
- Surgical wards were signed up to the Dementia Friendly Hospital Charter to improve and maintain a dementia friendly environment.

- Surgical wards followed the 'Vulnerable Inpatient Scheme' (VIP).
- The division handled 97% of complaints within trust timescales (95% target).

However:

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Service planning and delivery to meet the needs of local people

- The Mid Yorkshire Hospitals NHS Trust runs services across three sites in Wakefield (Pinderfields Hospital), Dewsbury and Pontefract. The trust has made changes to the way services are organised to ensure local people have access to the care they need when they need it, delivered by the most appropriate health professionals.
- In September 2016, the trust made changes to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care to improve clinical outcomes, access to urgent surgery, improve local treatment for non-complex planned surgery, reduce cancellations, improve surgical cover and reduce infection risk.
- The divisional business plan (2017/18 to 2018/19) supports the implementation of a comprehensive operational plan which delivers the trust strategic aims and links directly with capacity, workforce and financial plans.
- The trust was actively working with Clinical Commission Groups (CCG's) to provide an appropriate level of service based on demand, complexity and commissioning requirements. Commissioners were also involved in annual reviews of the service and discussion had been held with national commissioning groups.
- Advanced nurse practitioners worked on wards, running fracture clinics and holding arthroplasty clinics and also run clinics alongside orthopaedic consultants.
- Ward attendance clinics had been developed to provide aftercare following surgery and aimed to prevent re-admissions to the hospital.
- The trauma and orthopaedic service is consultant led and reviews of all hip and knee replacements are performed during the week in a weekly arthroplasty meeting. Network meetings are also held with neighbouring trusts from Sheffield, Huddersfield and Leeds on a regular basis for hip and knee replacements, upper limb & foot & ankle work.
- New ways of working had led to a number of improvements, e.g. reduced post treatment support and reduced waits for patients who required enteral feeding.

Access and flow

- The trust had 54,683 surgical spells between December2015 and November 2016. Emergency admissions accounted for 18,777 (34.3%), 30,317 (55.4%) were day admissions, and the remaining 5,589 (10.2%) were elective.
- A pre-assessment appointment was made with the patient before their surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Pre-assessment clinics were run by advanced nurse practitioners five days before surgery.
- Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust used enhanced recovery programmes to assist in patients recovering from orthopaedic surgery and included the mobilisation of patients on day zero after hip and knee replacement surgery. The MDT worked closely to support recovery and patients were routinely discharged with reduced length of stay.
- We saw that the care and rehabilitation of patients following surgery was particularly effective through the provision of on-going physiotherapy and occupational therapy services.
- A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity. Daily trauma meetings were held to discuss patients and to plan procedures. A database and patient management system for trauma management has been introduced.
- The trust average length of stay for surgical elective patients of 3.1 days (February 2016 to January2017) was lower than the England average (3.3 days). For surgical non-elective patients the trust average length of stay was 3.1 days in the same period, lower than the England average (5.1 days).

Surgery

- Between December 2015 and November 2016 the average length of stay for elective patients at this hospital was five days. For surgical non-elective patients, the average length of stay at this hospital was 0.2 days compared to 5.1 for the England average.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.
- The latest figures for January 2017, showed 44% of this group of patients were treated within 18 weeks versus the England average of 71%. Over the last 12 months there has been a gradual decline in performance.
- There were no surgical specialties above the England average for admitted RTT (percentage within 18 weeks). Seven surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).
- RTTs were not met within trauma and orthopaedics (43%, England average 65%), general surgery (61%, England average 75%), urology (74%, England average 79%), ENT (40%, England average 68%), ophthalmology (38%, England average 77%), plastic surgery (66%, England average 82%) and oral surgery (41%, England average 69%).The trust had developed a joint 'Planned Care Group' with the Clinical Commissioning group (CCG), with work streams addressing RTT issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- The National Cancer two week wait target of general practitioner (GP) referral to first appointment confirmed performance was 98% (target 95%) and the referral to breast first appointment confirmed performance was 97.4% (target 93%) between February 2016 and January 2017 across the division.
- However, the 62 days from diagnosis to treatment measure confirmed performance was 82.2% and did not meet national targets (85%) between February 2016 and January 2017.
- The hospital had an escalation policy and procedure to deal with busy times. Capacity bed meetings and cross site working was working well to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.
- However, across the trust, 726 procedures had been cancelled between January 2015 and December 2016 and 1% of these were not re-scheduled within 28 days. The trust's performance has been consistently better than the England average for the same period.
- Theatre utilisation at Pontefract Hospital ranged from 74% to 89% (October 2016 to December 2016).
- Two consultant led ward rounds were undertaken daily for general surgery to increase discharge and flow.

Meeting people's individual needs

- A trust-wide patient experience plan project had been developed which looked at five elements of patient care including privacy and dignity, sharing information with patients, staff communication with patients and their families, reviewing of patients emotional needs and reducing complaints.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthesia.
- We saw good access and facilities for wheelchair users and disabled bathrooms and toilet access. Signage, lifts and corridors at the hospital had tactile numbers and floor announcements for people with visual impairment.
- The division applied the 'This is me' personal patient passport and health record to support patients with dementia. Plans were in place for all admitted patients over age 75 years to be screened for potential and actual dementia and delirium. There were defined dementia care pathways across all surgical wards.
- Surgical wards were signed up to the Dementia Friendly Hospital Charter to improve and maintain a dementia friendly environment. A dementia lead and two healthcare assistants were in place and provided support and information for staff as necessary.
- Surgical wards followed the 'Vulnerable Inpatient Scheme' (VIP). The VIP symbol was used on the VIP hospital passport. The passport helped alert staff to additional patient needs and was accessible in patients notes and a VIP sticker was placed above the patients bed.

- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.
- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request. Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services. This ensured flexibility, choice and continuity of care.
- There were no mixed sex accommodation breaches over a 12 month period.
- Senior nursing staff were visible on the day of inspection and they reported that the ward manager and matron were available for patients and their relatives to speak to on a daily basis. It was made clear to patients and visitors to the wards who was on duty as this was displayed at the ward entrance.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required and the trust had policies in place covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'.
- There was a system in place for open and individual visiting for relatives and friends of patients.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.
- The trust had implemented the 'Forget-me-Not' scheme across all areas of the division. On discharge home 'Forget-me-Not' fridge stickers would be provided in the community and nursing homes.
- We saw a range of food choice, meals and snacks, safe storage and an additional supply of crockery and cutlery that met the needs of patients with dementia and staff had a good understanding of the nutritional needs of individual patients.
- Systems were in place to identify patients who required nutritional support to the catering staff. Details of dietary needs for individual patients were clearly identified on displays in the kitchen.

Learning from complaints and concerns

- Within the division 392 complaints had been received since April 2016 and trust data showed 97% of complaints were handled within trust timescales (95% target). Orthopaedic surgery received the highest number of complaints overall (134) across all three sites.
- Complaints were discussed at ward meetings as a standing agenda item. A full report was provided to the Directorate Operational Team (DOT) meeting on a monthly basis.
- Contact details for the Patient Advice Liaison Service (PALS) and Complaints were clearly available. Wherever possible the PALS team would look to resolve complaints at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as good because:

- There were clear governance processes in place to monitor the service provided. A clear responsibility and accountability framework had been established. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice were introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible. Staff had confidence in the new leadership and historic management clinician divides were not raised as an issue.

- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was a high level of pride and teamwork within the surgical division with staff speaking highly of their colleagues. They showed commitment to the patients, their responsibilities and to one another.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary.
- Actions were monitored through audit processes and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.

Vision and strategy for this service

- The trust is in a first wave implementation for the four priority 'Keogh' seven day standards of time to consultant review; access to diagnostics; access to consultant directed interventions; and ongoing review.
- Senior managers had a clear vision and strategy for the surgical division and identified actions for addressing issues. The strategy clearly identified the vision, behaviours and goals for the division.
- Specific objectives had been set for transforming and improving patient care, maintaining safety, developing a workforce for the future and financial sustainability, e.g. review the pre-op assessment process, ensure all staff within the division complete mandatory training and appraisal.
- The vision and strategy had been communicated throughout the division and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

- Staff told us that the governance framework had greatly improved. We were advised that divisional management meetings, divisional operational team meetings and clinical governances meeting took place each month. The risk register, incidents, complaints and lessons learned were discussed. Matrons disseminated information with ward staff at ward meetings and safety huddles.
- The team were involved in specific strategies, such as service reconfiguration, to meet the challenges within the division and had signed up to the changes to facilitate improvements. Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care. Ward managers, senior managers and clinical leads showed knowledge, skills, and experience.
- A clear responsibility and accountability framework had been established. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.
- The surgical division had a risk register, which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken.
- All senior staff in the service were responsible for monitoring performance and quality information. Measures included complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance. The matrons conducted audits of the ward areas with ward managers to measure quality.

Leadership of service

- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level.
- Clinical management meetings were held weekly and involved service leads and speciality managers. During inspection this approach was observed and reported to us by all levels of staff.
- Monthly surgical speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff at spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings, which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.

Surgery

Culture within the service

- Staff told us the division had strong leadership and senior managers were visible and engaged with staff. We interviewed a number of staff on an individual basis and held group discussions throughout surgical wards, theatres and units.
- Staff spoke positively about the service they provided for patients and high quality compassionate care was a priority. All staff were clear about their roles and responsibilities, patient-focused, and worked well together.
- At ward and theatre levels, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- All staff we spoke with felt that they received appropriate support from management to allow them to perform their roles effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Ward managers were given dedicated management time. This allowed them to focus on management and administrative issues. Management staff told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading their services.
- Most staff described good teamwork within the division and we saw staff work well together. There was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- However, some staff told us they had been working in difficult circumstances over a prolonged period to cover staff and skill shortages. Although, staff were enthusiastic about their work, the service they provided and the trust, staff morale was variable but had increased greatly in theatres with the advertising of new staffing posts.

Public engagement

- The trust engaged the public in assessing the hospital environment. This helped the trust to gain an understanding of how patients and service users felt about the care provided. Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.
- The NHS Friends and Family Test (FFT) in February 2017 showed 97% of patients would recommend the hospital to family and friends for respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. Patients were very complimentary about the care and treatment received.
- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and the Patient Advice and Complaints Service were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.

Staff engagement

- In the FFT staff survey (March 2017), 61% of staff within surgery said they would recommend the trust to friends and family as a place to receive care and treatment. The survey also showed 18% would not recommend the trust as a place to receive care and treatment; this had improved from 24%. The response rate was 22%.
- The survey showed 44% of staff would recommend the trust as a place to work, with 32% not recommending the trust as a place to work.
- We were told that management engaged with the staff more now than in recent years. We saw senior managers communicate to staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held staff meetings eight weekly, which discussed key issues for continuous service development.
- All staff were invited to speak with the ward manager and were able to voice their opinions, receive feedback and discuss any concerns.
- Staff we spoke to said they felt appreciated by the ward manager and listened to when they raised concerns. However, they did not feel as strongly when discussing the senior management team.

- Staff reported that most difficulties on the wards and theatre areas were related to staff shortages, which compromised their ability to provide more care and time for patients.

Innovation, improvement and sustainability

- Emergency Surgical Clinics were established in January 2017, which provided an opportunity for admission avoidance for the less acute patient that requires a surgical review. These patients were previously admitted and waited as an inpatient for this service. The service also provided fast track access to diagnostics for the patient e.g. ultra sound and CT scans as well as providing access to theatre lists, which provides 20 hours of expedited operating capacity.
- The Plastic Surgery Assessment Unit was developed November 2016. This was designed to improve the patient experience across the division and ensure capacity was maintained for the assessment of ambulatory patients that required a plastic surgery assessment by assessing patients direct from the emergency department.
- The trust had centralised acute surgery. All acute surgery has been provided at Pinderfields General Hospital since September 2016.
- The surgical division ran a Saturday service for joint injections. Joint injections under image intensification were removed from theatre and performed as outpatient activity in the dressing clinic to improve efficiency and response times.
- The trust developed and implemented a trauma dashboard for trauma and orthopaedics acute theatres to improve monitoring and flow.
- The urology department had been working with the local Clinical Commissioning Group (CCG) with the aim of keeping patients out of hospital whilst having their treatment.
- There were quality improvement projects within the urology department such as patient support groups, clinical trials and research, one stop clinics, patient direct contact, urology newsletter, safer patient flow pathway, hot clinics, CT/ultra sound access within 24 hours, and nurse led cystoscopes.

Maternity and gynaecology

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

Information about the service

Following a service re-design in September 2016, the Mid Yorkshire Hospitals NHS Trust provides women's services over three sites, with all inpatient and obstetric led maternity services amalgamated on the Pinderfields General Hospital site. There are two stand-alone midwifery led birth centres at Pontefract General Hospital and Dewsbury District Hospital, and a birth centre based at Pinderfields General Hospital.

The trust offered a limited range of services for women and families at the Pontefract General Hospital, this included, antenatal and gynaecology clinics, antenatal day unit and the Midwife-led Friarwood Birth Centre for women with low-risk pregnancies. The Friarwood birth centre had been open for seven years, and had recently had some improvement work carried out. The trust did not undertake any termination of pregnancy services.

Between April 2016 and April 2017 there were 218 babies born in the Friarwood Birth Centre.

In June 2015, CQC carried out an announced focused inspection. We rated safe as requires improvement well-led as good. The service was rated good overall.

During this inspection, we visited both antenatal and gynaecology clinics, antenatal day unit and the Friarwood birth centre. We reviewed three health care records three prescription records and spoke with three patients, one relative, and 12 staff including midwives, nurses, student midwives health care assistants, ward clerks, volunteers and receptionists. We also spoke with one member of medical staff.

Summary of findings

The overall surgery rating from the 2015 inspection was 'good''. Actions the trust were told they must take were:

- Check resuscitation and emergency equipment on a daily basis in order to ensure the safety of service users and to meet their needs.
- Ensure 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.

During the May 2017 inspection we rated the service as requires improvement because:

- We were not assured that staff were competent to use medical devices. There was also little assurance that electronic equipment had an annual safety checks
- We were not assured of the competence of staff with regard to basic skills such as cannulation and perineal suturing.
- Midwifery staffing was below nationally recommended levels at 1:31. Following our previous inspection the service reviewed staffing using a recognised acuity tool and this recommended a shortfall of 18 whole time equivalents. The service had an agreed plan to fill these posts over three years.
- The community midwifery caseloads were above the national recommendations

Maternity and gynaecology

- Attendance of hospital midwives at Obstetric emergency training was below the trust target of 95% at 86%.
- We found a lack of skills and drills scenarios on the Friarwood Birth Centre.
- There was little information for women whose first language was not English, and some staff were not aware this information could be accessed on the trust intranet system.
- Women experienced long waits at the antenatal clinic, and some were required to stand, as there was not enough seating.
- The risk register contained a large number of risks, and many had a review date in the past. This led to concern that the risk register was not being appropriately scrutinised.

However:

- Following our previous inspection there were robust practices in place to check emergency equipment.
- The service had bid successfully for Department of Health Safety training and had allocated the funding appropriately.
- We found good multidisciplinary working between midwifery and medical staff.
- We observed good and friendly interactions between staff, women and relatives.
- The service had a comprehensive business plan, which included plans to increase staffing levels including specialist midwifery posts.
- There was sympathetic engagement with staff and patients around the reconfiguration of maternity services.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were unable to tell us where practice had changed as the result of an incident.
- There was a lack of assurance in relation to medical device competencies.
- Data provided by the service showed attendance at mandatory obstetric training for midwives was below the trust target.
- There had not been regular skills and drills in the clinical areas including birth centre, antenatal clinic and antenatal day unit.
- Midwifery staffing and community midwifery caseloads were worse than the national recommendations.
- There were no visual signs of electronic safety checks on equipment.
- We were concerned with the storage of some drugs.

However:

- There were good infection prevention and control practices observed, and actions taken when the number of maternal infections increased.
- There were robust processes in place to check emergency equipment. We reviewed records and found these to be complete.

Incidents

- The trust had policies for reporting incidents, near misses and adverse events. All staff we spoke with said they were aware of the process to report incidents. We saw printed information in all clinical areas, which detailed what incidents should be reported. Staff reported incidents on the trust's electronic incident reporting system. Staff told us they received feedback about incidents they had reported.
- There were no Never Events reported for maternity and gynaecology between March 2016 and February 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- Between March 2016 and February 2017, there were no serious incidents reported by the Friarwood Birth Centre.
- Between March 2016 and February 2017 there were 171 incidents reported by women's services 160 of which were reported by the maternity service. Of these 142 incidents were reported as no harm, 18 were recorded as low harm. Themes identified included poor record keeping no customised or the wrong growth chart in hand held maternity notes and no consultant appointments available. The gynaecology service reported 11 incidents all of these were reported as no harm. The main theme for reporting was poor documentation and availability of electronic results.
- Staff were unable to tell us of specific cases where practice had changed as the result of an incident. The assistant director of nursing / head of midwifery that also identified this gap corroborated this.
- The service used a weekly safety brief to inform staff of learning and changes to practice and keep staff informed of the risks, which faced the directorate. We observed this brief was displayed in clinical areas.
- Perinatal mortality and morbidity were monitored through monthly perinatal meetings, which were attended by obstetric, paediatric and midwifery staff and reported quarterly to the trust mortality and morbidity steering group chaired by the medical director. Minutes of meetings from November 2016 to January 2017 included examples of the steering group reviewing cases and recommending changes to clinical guidelines and practice as a result. Staff informed us they would like to attend these meetings, however, due to the distance of travel and current staffing levels this has not been possible. Minutes were shared amongst senior staff and discussed at team meetings
- We spoke to staff that were aware of the principles of duty of candour, however, could not recall an occasion where it needed to be used. We also found examples of duty of candour in meeting minutes and incident report outcomes.

Safety thermometer

- Women's services had started using the national maternity safety thermometer. This allowed the maternity team to check on harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a method to quickly summarize the health of the newborn) of less than seven at five minutes.
- There was only trust wide data available. We found results for combined harm-free care between April 2016 and March 2017 showed the median value was 78%. This meant that on average 22% of women experienced an element of harm during their care. This was better than the national average of 75% (25% experiencing an element of harm) for the same period. Women's perception of safety had a median level of 92% for the same period, which was consistent with the national average. However, for three months we found data for the Trust showed this was significantly below 80%.

Cleanliness, infection control and hygiene

- We reviewed the infection control policy. The maternity department appeared mainly clean, however, patient toilets were unclean, and this had slightly improved by the time we left the site.
- We observed staff who did not wear protective equipment when testing urine samples.
- Trust policies were adhered to in relation to infection control; for instance, staff were seen to be bare below the elbows.
- We observed staff cleansing their hands following patient contact using hand gel provided.
- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (Difficile) in 2016/2017. There was one reported case of Methicillin-Sensitive Staphylococcus Aureus (MSSA).
- We saw 'I am clean' stickers on all equipment.
- We found fully completed cleaning rotas placed in clinical areas; most clinical areas were visibly clean and well organised. We found the shared dirty utility between the antenatal and gynaecology outpatient department was disorganised, with no clear rota identifying which department was responsible for maintenance.
- At 36 weeks of pregnancy all women were screened for MRSA; if they had a positive result, they were given treatment prior to admission.

Environment and equipment

Maternity and gynaecology

- At previous the previous inspection 2015 we were concerned with checks on emergency and resuscitation equipment was not always completed. During this inspection, we found all checks on emergency and resuscitation equipment were complete.
- The premises and facilities at the hospital were appropriate for the services provided there. We found the waiting area for the antenatal clinic was small, meaning that some pregnant women and their partners/relatives were forced to stand whilst waiting for their appointments; at the time of our inspection the clinic was running late, and so some patients had been standing for up to an hour. Furthermore, there was very little space around the reception desk, meaning that it was not possible for patients to speak privately with the receptionist in this area.
- There was adequate equipment on the unit to ensure safe care – specifically, cardiotocography (CTG), resuscitation equipment and directional lights. Staff confirmed they had sufficient equipment to meet patient needs.
- The Friarwood Birth Centre had four en suite rooms in total. One room had a birthing pool with a ceiling hoist to aid evacuation from the pool in an emergency.
- The day assessment unit had three couches and chairs, divided by curtains. We did not observe any couches, which were labelled as suitable for women with raised body mass index (BMI). Staff were unable to inform us of the weight limits on the couches.
- We observed electronic equipment; we found that a large amount of equipment showed no visible evidence of electronic safety checks. We raised a concern with staff that was not aware of this. Information received from the trust dictated that all electronic equipment should have visible evidence of safety testing displayed.
- The Antenatal and gynaecology clinics were joined and shared dirty and clean utility areas, however, we found checking of equipment such as urinalysis machines was not shared equally. The dirty utility was disorganised and had no clear rota to assign responsibility.
- The service undertook annual medical devices competencies. Compliance with the completion and return of a personal training assessment was 1.3%. However, the service was confident that staff were trained in the use of medical devices and was working to improve the process to capture data to demonstrate this.
- Home birth bags were stored and collected from the birth centre by the community midwives. It was the community midwives responsibility to check these bags and equipment prior to them leaving the unit.

Medicines

- We found syntometrine, syntocinon and ergometrine stored in a homebirth bag. These medications should be stored at a low temperature; they can be stored at room temperature for a limited amount of time. There was no indication when the drugs had been removed from the fridge. We raised this concern with staff, who told us that this information was recorded in the unit diary. On further investigation, staff were not able to assure us when the drugs needed to be changed. Following our inspection, we have received information that these drugs now are now labelled directly to identify when they were removed from cold storage.
- We found water for injection ampules on an open trolley. We highlighted this with clinic staff and they were locked away appropriately.
- We reviewed two prescription charts and found them in line with trust policies.
- Medicines were stored in locked cupboards and trolleys in all clinical areas.
- Medicines that required storage at a low temperature were stored in a specific fridge. Fridge temperatures were monitored remotely; however, we reviewed records dating back to March 2017 and found them to be complete, including the documentation of maximum and minimum temperature
- The Friarwood Birth Centre did not stock controlled drugs.
- There were processes in place to record all medications dispensed by midwives under patient group directives (PGDs) during the discharge process. This included checks by two midwives and stock control sheets for the pharmacy department. PGDs are written instructions to help supply or administer medicines to patients, usually in planned circumstances.

Records

- The service kept medical paper records securely in line with the data protection policy.
- Women carried their own records throughout pregnancy and postnatal periods of care.

- We reviewed two medical records and found that antenatal risk assessments were not completed, but entries were dated, timed, and signed.
- The service completed bi-annual record-keeping audits. We reviewed the audit undertaken from June to November 2016, in which 242 antenatal, intrapartum (labour) and postnatal records were checked. We found 17% (n29) of the areas assessed were not compliant in up to 70% of the records. These included; Woman's name and unit or NHS number on each page in the postnatal record (38%); Mental health risk assessment completed in second trimester (25%); and General record keeping in neonatal notes was between 36% for baby's surname and unit or NHS number on each page and 88% of all entries signed. The audit included recommendations, and plans were in place to repeat the audit in July 2017.
- Following previous audits, and following recommendations from RCAs, the service had implemented new-style records in January 2017, with the aim of improving ease of use for staff. However, we did not have any feedback from staff to corroborate this.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children. The safeguarding midwife was integrated into the safeguarding team.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. Staff reported they were happy to contact the safeguarding team for advice and support if required.
- Midwives received annual safeguarding level three training in line with the Royal College of Paediatrics and Child Health (2014) intercollegiate guidelines. Between April 2016 to March 2017 records showed 91% of midwives had completed this training against a target of 85%.
- Community midwives were required to have four safeguarding supervision sessions per year; these consisted of three group supervision sessions and at least one, one to one session. Hospital based midwives were offered supervision based on need.
- Records showed 97% of midwifery staff had completed safeguarding adult's level one training. Additionally 98% of staff had received level one mental capacity act training; this was above the trust target of 95%.
- The Friarwood Birth Centre had a baby abduction policy. There was a video call system onto the unit with a push button exit. All paths out of the unit were in full view of manned reception desks. There was no infant alarm system, in place; babies stayed with mothers at all times.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Senior clinical staff told us there had been training about FGM the previous year, which raised awareness. A guideline was in place to support staff in the identification of those at risk of FGM and management. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it is now mandatory to record this in the patient's health record; there was a clear process in place to facilitate this reporting requirement.

Mandatory training

- Midwives, health care assistants (HCA) and medical staff attended a one-day Yorkshire maternity emergency training (YMET) obstetric mandatory programme, which included emergency skills and drills, human factors training and Sepsis. There was a strong reliance that staff attended YMET as a priority. Data provided by the trust showed that 86% of birth centre and community midwives between April 2016 and March 2017 had attended this training against a target of 85%.
- All attendance at training provided by the service (including CTG training, screening and safeguarding run over two days) was monitored by the midwifery clinical educator and matrons. Staff were automatically rostered to attend mandatory training. We reviewed data, which showed 88% of midwives, nurses, and HCAs allocated attended day one and 82% of staff attended day two against a trust target of 85%. We were told that non-attendance at mandatory training was treated seriously and escalated to the matrons and HOM, as required.

Assessing and responding to patient risk

- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to Pinderfields General Hospital.
- There was a robust midwifery led care policy, which identified the criteria for women being able to deliver within the unit and at home. Staff informed us as soon as they were concerned they called for an emergency response ambulance.
- The service carried out MEWS audits, to ensure compliance with completing and escalating deteriorating patients. We reviewed the February to April 2016 audit, which showed a compliance rate of 84% to 90%. The audit clearly documented recommendations and associated action plans; this included adding the audit to the annual audit priority programme.
- There were clear guidelines for the antenatal day unit; this included the thresholds at which they could accept patients such as cut off levels for raised blood pressure.
- Staff on the birth centre had not had any additional training over and above their mandatory training such as advanced obstetric life support (ALSO) or neonatal life support (NLS).

Midwifery staffing

- The service did not meet the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:32 across both community and hospital staff against the recommended 1:28. The service did not include maternity support workers within the establishment, which would allow a 10% skill mix of staff.
- The service used Birthrate Plus® to enable a comprehensive review of midwifery staffing numbers based on the different models of care. The review identified a shortfall of 18.42 staff. The service had plans in place to recruit to these posts from 2017 to 2020. Women told us they had received continuity of care and one-to-one support from a midwife during labour. The trust reported the percentage of women given one-to-one support from a midwife was good.
- We found staffing levels displayed. We reviewed staff "off duty" and found a correlation between planned versus actual staffing numbers.
- Community midwifery caseload numbers were reported as 1:105 this was worse than the national recommendation of 1:98
- The service used NHS professionals (NHSP) to fill gaps in the planned number of staff. A number of substantive staff was signed up to NHSP and the agency provided a number of familiar staff to the maternity unit, this providing continuity.
- Community midwives were on call for home births and additional staffing on the birth centre. There was a clear escalation process to call in additional staff and from which community midwifery team.
- As of 28 February 2017, the trust reported a vacancy rate of 5% in Maternity and Gynaecology.
- Between March 2016 and February 2017, the trust reported a turnover rate of 16% in Maternity and Gynaecology.
- Between March 2016 and February 2017, the trust reported a sickness rate of 6% in Maternity and Gynaecology.
- Between March 2016 and February 2017, the trust reported a bank and agency usage rate of 8% in Maternity and Gynaecology.

Medical staffing

- There were no medical staff based at the birth centre, however, consultants attended for antenatal and gynaecology clinics.
- Staff on the antenatal day unit informed us if they were concerned; they contacted a consultant at Pinderfields General Hospital for advice.

Major incident awareness and training

- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- There was a 100% vaginal birth rate.
- The service had bid successfully for Department of Health Safety training monies. It was in the process of allocating staff to training courses.
- There was good multidisciplinary working between medical, nursing and midwifery staff.
- The service was delivering care in line with national guidance.

However:

- Data provided showed that attendance at the Yorkshire Maternity Emergency Training (YMET) was below the trust target.
- There was not a regular programme of skills and drills on the Friarwood Birth Centre, antenatal clinic and antenatal day unit.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet. We observed policies were easily accessible and filed logically and were in date.
- We were told staff consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Some staff we spoke with said this was not the case. Policies and procedures were available on the trust's intranet and approved by the clinical governance group. The policies we reviewed (post-partum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in-date and in line with best practice.
- From our observations and through discussion with staff, care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- There was evidence to indicate NICE Quality Standard 37 guidance was being met. This included the care and support that every woman, their baby and as appropriate, their partner, and family should expect to receive during the postnatal period.
- The unit was implementing the NHS funded Saving Babies in North England (SaBiNE) which was a care bundle for still birth prevention, through improved antenatal recognition of fetal growth restriction. At the time of inspection, there was no project lead for this work stream and additional capacity was required for the additional scans required. Plans were in place to increase scanning capacity through the training of midwife sonographers.
- Following the reconfiguration of services to the Pinderfields site, we found a lack of additional audit activity. For example, there were no pain audits. We were also told that junior (e.g. band five and six midwifes and junior doctors) staff were not invited to take part in audit activity.

Pain relief

- Women received detailed information of the pain relief options available to them, this included Entonox piped directly into the delivery rooms.
- The birth centre had one birth pool with a ceiling hoist for use in an emergency evacuation. There was equipment to support active labour. Pharmacological pain relief options were limited to Meptazinol (Meptid). Women on the birth centre who requested epidural analgesia were transferred to Pinderfields General Hospital labour suite.
- The trust did not undertake pain relief audits or collect this data.
- The service did not actively promote alternative therapies for example hypnobirthing; however, we were told they supported women who chose this method of pain relief and staff had been trained.

Nutrition and hydration

- There was an infant feeding co-ordinator; their role included training staff, division of tongue-tie clinics, supporting breastfeeding mothers on the postnatal ward and in the community.
- Breastfeeding initiation rates for deliveries that took place in the hospital for April 2016 to March 2017 were reported at between 64% and 75%, which was worse than the England average of 76%.
- The trust had implemented United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit had achieved full accreditation for maternity services and at the time of inspection were awaiting assessment for re-accreditation.

- Women who chose to formula feed their baby were asked to bring their own powdered formula and bottles into the unit. Women were supported to make their formula correctly during their stay on the Friarwood Birth Centre.
- Women were able to have light meals and snacks during their time on the birth centre.

Patient outcomes

- The birth centre had 100% normal vaginal delivery rate, which was better than the national average of 60%.
- The transfer rate of women to the Pinderfields General Hospital was 53%, which was greater than the target of 25%. We were told each transfer was reviewed and all were clinically appropriate such as failure to progress in the first stage of labour.

Competent staff

- Matrons and managers monitored staff training monthly. They allocated staff to training and used the appraisal system to identify the need for additional training.
- The appraisal rate up until February 2017 was 100%for medical staff and 68% other categories of staff. All staff we spoke with informed us their appraisal was up to date and found it to be a useful experience.
- Healthcare support workers attend YMET training to support the delivery of services and examples of subjects included the care of deteriorating patients and MEWS, maternal observations, skills drills, breech births, pre-eclampsia and neonatal life support.
- Staff told us that there was little skills and drills activity on the birth centre.
- We were concerned, about staff competency in basic skills such as cannulation and suturing. The Friarwood birth centre had been open for seven years and many of the staff already worked there. Staff told us there was no formal rotation programme to the consultant unit to update on basic skills. We reviewed the training calendar with the education midwife and found there were limited training days for staff to learn cannulation. We were told staff could call the on call site medical team in emergencies prior to ambulance crews arriving if required.
- There was no rotation of staff around all areas of the service. We were told plans were being developed to facilitate this.
- Following the change in legislation, (April 2017) the statutory role of the supervisor of midwifery (SOM) no longer existed. The service had decided to implement a role called midwifery advisors. These previous SOMs were on call for 24 hours to provide independent advice and support as required. The Midwifery advisors did not undertake formal supervision of midwifery staff.
- Staff on the birth centre had not had any additional training over and above mandatory update training, such as advanced obstetric life support (ALSO), or neonatal life support (NLS).
- The service had successfully bid for department of health safety training funding. At the time of our inspection, courses were being allocated to staff such as ALSO, NLS, and critical care courses. There was some confusion between staff regarding who was prioritised for training. The education midwife informed us that the staff in the stand-alone birth centres were prioritised for NLS and ALSO training.

Multidisciplinary working

- We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.
- Staff confirmed there were close working relationships between the gynaecology specialist nurses and consultants.
- Antenatal day unit staff called the medical team at Pinderfields General Hospital should there be any concern. We asked why they did not call on doctors in the antenatal clinic. We were told they were often too busy and clinics often ran late.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.

Seven-day services

- This service was staffed by the midwifery team 24 hours a day, seven days a week.
- The antenatal day unit was open Monday to Friday 8.30am to 5.0pm.
- The Gynaecology clinic was open Monday to Friday 8.30am to 5.00pm.

Access to information

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet. We observed policies were easily accessible and filed logically.
- Blood results were available on the electronic results system.
- The service had its own dedicated area on the trust website. Pregnant women and their families could access this site; however, the information did not include information on the different units available for women to deliver. There was no information about gynaecology service on the website as it was identified as not yet available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an understanding of mental capacity and described the process of caring for women who may lack capacity. Ninety-eight percent of staff had completed MCA level 1 training against a target of 95%.
- At the time of our inspection, the trust was seeking to recruit a 1.0 WTE Band 7 lead midwife specialising in mental health issues.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Most women we spoke with were positive about the standard of care they had received, as were their partners and families.
- We observed staff interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.
- The trust performed similarly to the England average across all maternity aspects of the Friends and Family Test (FFT) and for all of the 16 questions in the CQC Maternity Survey 2015.

Compassionate care

- Most women we spoke with who were using the maternity and gynaecology services were positive about the standard of care they had received.
- Women using the maternity services told us that they had named midwives, they received good continuity of care from community midwives, they felt well supported and cared for by staff, and their care was delivered in a professional way.
- Most women we spoke with in the maternity service described how staff took time to allow them to understand and form choices, promoted privacy and dignity during personal care, and were compassionate when they experienced pain, discomfort, or emotional distress.
- The population served by Pontefract Hospital was culturally and ethnically diverse, and women attending the hospital and birthing centre during our inspection were from a variety of backgrounds. Most of the women we spoke with did not express any concern about staff understanding of their personal, cultural, social, or religious needs.
- We observed staff in the hospital interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.
- From February 2016 to February 2017, the Friarwood Birth Centre FFT (antenatal) performance (% recommended) was similar to the England average: in February 2017, performance for antenatal care was 97%; the national average was 96%.
- From February 2016 to February 2017, the Friarwood Birth Centre FFT (birth) performance (% recommended) was similar to the England average: in February 2017, performance for birth was 100%; the national average was 97%.
- There was no site-specific FFT data for postnatal care.
- The trust performed about the same as other trusts for all of the 16 questions in the CQC Maternity Survey 2015.

Understanding and involvement of patients and those close to them

- Women were involved in their care throughout the antenatal, birthing, and postnatal periods. We observed staff involving women in the planning of their care, and most women we spoke with said they felt involved in their care and understood the choices open to them.
- Women were encouraged to visit the Friarwood Birth Centre for a tour before deciding where they wanted to give birth and/or to familiarise themselves with the facilities.

- Women we spoke with at the hospital told us that their partners and other family members were as involved in their care as they wanted them to be. Partners and relatives we spoke with agreed that they felt involved and that staff were caring, polite, and helpful.
- There was provision for partners to stay with women and their newborn babies in family rooms in the Friarwood Birth Centre.
- A range of leaflets was available for women to take away with them to help with decision-making, and women we spoke with confirmed that they had been given appropriate information to take away at previous visits. There was also clear information available on the trust's website.

Emotional support

- A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss.
- All women who were planning a vaginal birth following a previous caesarean section (VBAC) were seen by a consultant obstetrician and offered an appointment at a birth choices clinic.
- A specialist diabetic nurse supported the hospital's weekly diabetes antenatal clinic.
- At the time of our inspection, the trust's 1.0 WTE Band 7 lead midwife for vulnerable women post was vacant, meaning that there was no dedicated specialist support for vulnerable pregnant women, including teenagers.
- At the time of our inspection, the trust was seeking to recruit a 1.0 WTE Band 7 lead midwife specialising in mental health issues.
- The trust did not provide us with any information about its approach to antenatal and postnatal assessments for anxiety and depression, nor on the availability of counselling services for women whose assessments might indicate a need for these.
- The trust did not provide us with any information about the availability of counselling services for women undergoing gynaecological surgery or procedures.
- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death. The trust had a 0.6 whole time equivalent (WTE) Band 7 bereavement lead midwife, whose role included ensuring that pathways and processes were in place for bereaved families. It also had a 0.2 WTE Band 6 bereavement specialist midwife, who held a counselling qualification and had a special interest in caring for bereaved families.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Women whose pregnancies were low-risk were able to choose to deliver at home, in the midwifery-led birthing centre, or in the labour ward at Pinderfields General Hospital (PGH).
- The trust had held a listening workshop for new mothers and staff, with the aim of improving the experience of all women using its maternity services. It was in the process of implementing the improvement plan generated by that workshop.
- There was a consultant midwife clinic to support women in their birth choices, including vaginal birth after caesarean.
- The service was exceeding the Newborn & Infant Physical Examination (NIPE) indicator.

However:

- Women were not always reviewed in a timely manner at consultant-led clinics.
- There was a lack of specialist midwives in post to support vulnerable women and those needing additional support for other reasons.

Service planning and delivery to meet the needs of local people

- The maternity service at Pontefract Hospital provided an antenatal service, including pregnancy screening clinics and an antenatal day unit, and a midwifery-led birthing centre.
- Women using the service at Pontefract Hospital were those whose pregnancies were assessed as low-risk at their booking appointments. They were then able to choose to deliver at home, in the midwifery-led

Friarwood Birth Centre, or in the labour ward at PGH. Those who were assessed as high-risk could continue to use the antenatal service at Pontefract Hospital but would travel to the labour ward at PGH to give birth.
- Partners were encouraged to stay in the birthing centre with mothers and babies following delivery, until discharge.
- Community-based maternity services were provided from a number of locations within the area; these were predominantly GPs' surgeries, children's centres, and women's own homes.
- The gynaecology service at Pontefract Hospital provided an outpatients clinic. There were a number of nurse-led and consultant-led clinics.
- The population served by Pontefract Hospital was culturally and ethnically diverse, and women attending the hospital and birthing centre during our inspection were from a variety of backgrounds. Most of the women we spoke with did not express any concern about staff understanding of their personal, cultural, social, or religious needs.
- The trust had held a workshop that brought together new mothers and staff in March 2016, with the aim of improving the experience of all women using its maternity services. The workshop generated a list of 'always events' (experiences of care which are so important to patients and families that healthcare staff should aim to perform them consistently and reliably for every patient, every time) under the Institute for Health Care Improvement's (IHI's) Always Events Framework. These always events were then used to develop an improvement plan, which the trust was in the process of implementing at the time of our inspection.
- The service worked with community services and public health to provide continuity of support for breastfeeding once women had left the service. The trust supported three local, volunteer-run, weekly, breastfeeding cafes, which women could attend for support and advice.

Access and flow

- From April 2016 to March 2017 the average monthly transfer rate from the Friarwood Birth Centre to PGH was 53%. Staff told us that all reviewed transfers had been clinically appropriate and that there had been no occurrences of women inappropriately attending the birthing centre. It was trust policy to report any inappropriate transfers or attendances as incidents using the Datix incident reporting system.
- We were told that there was ongoing review and monitoring of trends in transfer rates and any practice issues highlighted would be addressed by the consultant midwife and raised in women's clinical governance, quality, and performance meeting agendas.
- The trust's incident recording system had identified that there were delays in obtaining consultant appointments at Pontefract Hospital due to cancelled clinics; we found that this issue was noted on the women's services risk register. Weekly meetings were held to look at the rota and the performance team was putting measures in place to reduce the future risk.
- From April 2016 to March 2017, the maternity service at Pontefract Hospital was closed on four separate days. The closures were due to capacity issues in the neonatal unit at Pinderfields General Hospital (PGH), and workload, capacity, and/or acuity issues on the labour ward at PGH. Staff told us that the service at Pontefract Hospital closed whenever the service at PGH was closed, to ensure that there was no risk of being unable to transfer any woman who might develop the need for obstetric care.
- The hospital did not monitor the percentage of women seen by a midwife within 30 minutes of arrival during labour. However, it was normal practice for midwives to greet women immediately on their arrival at the birthing centre, and none of the women we spoke with said that they had been left unattended at any time.
- The trust had set a target of 90% of pregnant women accessing antenatal care within the first 13 weeks of pregnancy. This target was not met in four of the 12 months up to and including March 2017. Nonetheless, the average monthly percentage across the trust for that year was 90.5%.

Meeting people's individual needs

- A 'Birth Matters' clinic, promoting normal birth, was available at the trust. This was held at Pontefract Hospital once every three weeks. The trust employed a 1.0 WTE consultant midwife for normality and a 0.8 WTE midwifery advisor specialising in normality.
- At the time of our inspection, the trust's 1.0 WTE Band 7 lead midwife for vulnerable women post was vacant. The purpose of this role when filled would be to work with the most vulnerable women using the service, including teenagers.

- Named midwives were responsible for providing support and ensuring policy implementation in areas such as substance misuse and the reporting of female genital mutilation.
- The trust had previously trialled the 'Baby Clear Initiative' to support pregnant women to give up smoking. However, it had not yet implemented the initiative following that trial. The public health midwife told us that recruitment of a 'stop smoking midwife' was planned for the summer of 2017 and the principles of the Baby Clear Initiative should therefore be implemented by the end of 2017.
- At the time of our inspection the trust was seeking to recruit a 0.6 WTE Band 7 stop smoking midwife on a one-year, fixed-term contract and had arranged mitigating actions to avoid compromising patient care during service reconfiguration and recruitment. Actions taken included arranging for the public health midwife to lead on smoking cessation and to liaise with commissioners to ensure multidisciplinary working, implementing carbon monoxide monitoring at booking and introducing an opt-out (via electronic referral) service for stop smoking services.
- The trust was achieving the quality standard of more than 90% of women being offered carbon monoxide monitoring at booking.
- There was a weekly, specialist, antenatal clinic at the hospital for women with diabetes. A midwife and a specialist diabetic nurse ran this jointly to ensure continuity of care at clinic appointments.
- The service was in negotiation with local Clinical Commissioning Groups (CCGs) to improve services for pregnant women with Body Mass Indices (BMIs) of over 35. Additionally, midwife sonographers were undertaking training to perform foetal growth scans for these women, and the service was considering the development of a specialist clinic alongside scanning, to offer specialist support and coordinate interventions.
- Staff we spoke with told us the service made adjustments for women with learning disabilities, for example, allowing a carer to stay with a patient.
- The trust's website could be viewed in over 100 different languages.
- Translation services were available in person and via the telephone. Staff we spoke with assured us that they would never rely upon patients' friends or family members to translate.
- All notices displayed in the waiting areas were in English only.
- There were no toys for children to play with in the antenatal clinic waiting area, and, at the time of our inspection, there was not enough seating in this area to accommodate all of those who were waiting.
- The trust reported that the percentage of babies examined under NIPE criteria within 72 hours of birth was 98%, which exceeded the NIPE indicator of 95%.

Learning from complaints and concerns

- Leaflets explaining the complaints process were available in most areas. There was also information about the process on noticeboards in the antenatal and gynaecology clinics' waiting areas. Information about how to contact the Patient Advice and Liaison Service (PALS) was included.
- The trust had received three complaints relating to maternity services at Pontefract Hospital from March 2016 to March 2017 inclusive. Of these, one was upheld and two were partially upheld.
- The service responded to complaints in a timely manner, with responses provided within the timescales set out in the complaints policy.
- Learning from complaints about the maternity service was disseminated by a weekly, trust-wide, maternity service safety briefing, which was read out at each staff handover session for a week, emailed to all staff, and displayed in clinical areas.
- Trust policy directed that one-to-one feedback should be given to staff who had been directly involved in any matter triggering a complaint.
- The head of midwifery told us that, although learning from complaints was disseminated amongst staff, the trust did not necessarily make it clear when practice had changed following the addressing of a complaint.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- The service had successfully reconfigured services to one consultant let site and two standalone birth centres.

- There was a clear business plan for women's services, which was aligned to the corporate priorities.
- There were good processes in place to monitor clinical governance, risk management, performance and quality.
- There were clear and defined roles within the senior leadership team. Staff were aware of these roles and knew who the senior leadership team were.
- The service actively engaged with women through the maternity services liaison committee based in Kirklees.
- The service had fully engaged with staff during the acute hospitals reconfiguration including preferred hospital base.
- The service had benchmarked against the national maternity review and had a clear action plan in place to achieve compliance.

However:

- Staff reported the head of midwifery was rarely seen on the birthing centre as her focus was the consultant unit.
- Lack of assurance the risk register was managed robustly owing to the number of risks on it and the number of review timescales that had lapsed prior to our inspection.

Leadership of service

- Maternity and gynaecology formed part of the Women's Services Directorate. There was a clear managerial structure, which included clinical engagement.
- The triumvirate consisted of the Deputy Director of Operations, head of clinical services (one each for obstetrics and gynaecology) and the Assitstant Director of Nursing and Midwifery for Women's Services.
- The leadership team had successfully reconfigured women's services from two consultant led maternity units and one standalone midwifery led unit; to one consultant led maternity unit with an alongside midwifery led unit, two standalone midwifery led units.
- Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme and through 1:1 meetings with managers.
- We observed a cohesive senior leadership team who understood the challenges for providing good quality care and identified strategies and actions to address these. This was evident in discussions around the development of the unit and the recent reconfiguration of services.
- The assistant director of nursing and midwifery was also the head of midwifery (HOM) was not often seen on the birth centre, staff told us her focus appeared to be on the consultant led unit at Pinderfields Hospital.
- The matron was visible and the senior midwife service manager was a daily presence. Staff were clear about who their manager was and who members of the senior team were.

Vision and strategy for this service

- The service had a clear business plan for women's services. The business plan included the recent acute hospital review and the maternity improvement plan.
- The service business plan had strategic objectives, which were aligned to the trust priorities. Strands included growth in targeted areas, building capacity and improving efficiency and midwifery supervision.
- All staff we spoke with were aware of this vision.

Governance, risk management and quality measurement

- There was a defined governance and risk management structure. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. Staff were aware of their roles and responsibilities in relation to governance
- The women's clinical governance meeting occurred monthly at Pinderfields General Hospital to monitor safety and risk throughout the directorate. We reviewed meeting minutes and found focused and detailed discussion with clear outcomes and actions.
- The quality and performance group meet monthly to discuss outcome and performance data. The service had a comprehensive dashboard, which enabled them to monitor performance and identify any trends and concerns.
- Risk registers assisted the management team and senior staff to identify and understand the risks. The risk register was a live document and all staff were able to access it through the trust intranet.
- The service provided a copy of the risk register were 67 risks identified for maternity and gynaecology. All were ordered in the level of the risk (highest to lowest)

existing controls and gaps, and action necessary. For example, the risk of obstetric antenatal clinics running late or cancelled at last minute due to the complexities of the obstetric rota achieving the 98 hours a week labour ward cover. All risks had a review date next to them. However, 70% (47) of the review dates were prior to our inspection.

- All staff we spoke with had an awareness of the duty of candour regulations that came into effect on 27 November 2014. Policies on being open were in use and an open culture was observed.
- The service had completed a gap analysis following the publication of the Kirkup report (2015). All identified gaps had clear actions documented against them. We reviewed evidence that the directorate had reviewed the actions since the initial analysis.
- The service had benchmarked themselves against the Better Births - National Maternity Review (2016). All identified gaps had clear actions documented against them. We reviewed evidence, which demonstrated the service had updated this analysis.

Culture within the service

- We found an open culture with the emphasis was on the quality of care delivered to women. Staff told us there was a 'no blame' culture where staff could report when errors or omissions of care without fear. For example, staff we spoke with informed us they were encouraged to reflect on adverse incidents as soon as possible. This included staff that may even have been in to inform a patient of a phone call or provide a drink.
- We observed strong individual team working, however, we were told that if one clinical area were experiencing increased activity, staff from other areas would not support. For example, if the antenatal day unit were busy staff from the birth centre would not be able to help.
- Staff told us about the 'open door' policy at department and board level. This meant they could raise a concern or make comments directly with senior management, which demonstrated an open culture within the organisation.

Public engagement

- The service actively sought the views of women and their families through the maternity services liaison committees (MLSC) for Wakefield. This was a functional group, which met quarterly respectively.
- The service also developed a patient experience action plan with measurable goals and was red amber green (RAG) rated.
- The service has undertaken a local health needs assessment to identify the hard to reach communities and working with local partners such as commissioners to support them effectively.
- The service consulted with women during the reconfiguration of the services. Women were invited to walk round the birthing centre when they attend the hospital for routine appointments and visits to the day assessment unit.

Staff engagement

- There were no directorate specific results in the 2016 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with five being highly engaged and one being poorly engaged, the trust scored 3.57. This score placed the trust worse than trusts of a similar size.
- We spoke with staff and in all areas, staff were very engaged and felt involved in the service throughout the reconfiguration of maternity services. A consultation asked staff to identify the area and hospital they would like to work in order of preference.
- There was a weekly staff bulletin to inform staff of up to date guidance, changes to practice and updates of information within the trust.
- We observed staff reading the weekly safety brief, which informed them of changes to guidelines and evidence from within maternity services.

Innovation, improvement and sustainability

- There was an extensive number of nurse led gynaecology clinics, which were overseen by the gynaecology specialist nurse, supported by band five nurses.
- There were fast tract clinics for women with post-menopausal bleeding which included same day access to diagnostic outpatient procedures.

Outpatients and diagnostic imaging

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provided a range of outpatient and diagnostic imaging services from three hospitals, Dewsbury and District Hospital, Pinderfields Hospital and Pontefract Hospital.

Between December 2015 and November 2016 there were 506,250 first and follow-up outpatient appointments at the trust. There were 157,764 outpatient appointments at Pontefract Hospital between December 2015 and November 2016.

We visited the main outpatient department, ophthalmology outpatients, physiotherapy outpatients, pathology and diagnostic imaging.

The service had an access, booking and choice directorate. These were responsible for the outpatient departments and based at Pinderfields Hospital. The booking centre was based at Pinderfields Hospital.

Diagnostic imaging services were mainly provided from three locations: Pinderfields General Hospital, Pontefract General Infirmary and Dewsbury General Hospital. Diagnostic imaging at Pinderfields General Hospital provided plain film x-rays, ultrasound, CT, and MRI. The acute clinical work including fluoroscopy was concentrated at Pinderfields General Hospital.

Diagnostic imaging services were available for inpatients and trauma patients 24 hours a day, every day of the year. Outpatients and those referred by their GPs could access plain film services from seven days a week between 8am and 8pm and for MRI and CT there were appointments from 8am to 8pm on weekdays. Ultrasound services were provided from 8am to 6pm on weekdays. The service provided extra appointments for evenings and weekends to meet demand. Diagnostic imaging services booking team organised and booked appointments for procedures and follow ups for all hospital sites from the radiology booking centre at Pontefract General Infirmary.

During the inspection of diagnostic imaging services at Pontefract General Infirmary, we spoke with two patients, two relatives and three staff including a manager, a doctor, and a radiographer, all of whom worked across the three hospital sites. We observed the diagnostic imaging environments, checked five electronic records, equipment in use and looked at information provided for patients. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Records we reviewed confirmed that there continued to be a steady increase in demand for diagnostic services.

We spoke with 17 staff, five patients and reviewed one patient record in outpatients.

Outpatients and diagnostic imaging

Summary of findings

The Mid Yorkshire Hospitals NHS Trust was inspected previously between the 23 and 25 June 2015 as part of a follow up inspection. The previous inspection rated safe as good, effective as not sufficient evidence to rate, responsive as requires improvement and well led as good. Previous issues identified included capacity issues, cancellation of appointments and not consistently achieving referral to treatment indicators.

We rated this service as requires improvement because:

- Staff told us clinical validation had occurred on some waiting lists, for example in ophthalmology. However this had not occurred on all backlogs across the trust.
- There were issues regarding referral to treatment (RTT) indicators and waiting lists for appointments. There was an appointment backlog which had deteriorated since the last inspection and was at 19,647 patients waiting more than three months for a follow up appointment.
- No specialties were above the England average for non-admitted referral to treatment (RTT) (percentage within 18 weeks), however the trust were progressing work on addressing this with a trajectory to be achieving the indicators by March 2018.
- Duty of candour was not well understood across all staff groups; however senior managers could describe the duty of candour.
- Appraisals completion rates did not always achieve the trust target.
- In main outpatients, team meetings did not always happen monthly. Managers were aware of this and told us they were addressing consistency of team meetings in main outpatients.
- The trust did not measure how many patients waited over 30 minutes for imaging within departments.

However:

- A trust incident reporting system was used to report incidents and staff we spoke with were aware of how to report incidents. Staff were aware of how to report safeguarding concerns.
- Areas we visited were visibly clean and tidy. Medicines checked were found to be stored securely and were in date. Staff told us records were available for clinics when required.
- Actual staffing levels were in line with the planned staffing levels in most areas.
- Staff provided compassionate care to patients visiting the service and ensured privacy and dignity was maintained. Diagnostic services were delivered by caring, committed and compassionate staff.
- The Did Not Attend (DNA) rate was lower than the England average.
- Managers were able to describe their focus around addressing issues with the referral to treatment indicators and addressing waiting times. There were referral to treatment recovery plans in place for various specialties.
- Risk registers were in place and managers took risks to the divisional governance meetings. Management could describe the risks to the service and the ways they were mitigating these risks.
- Most staff we spoke with told us managers and team leaders were available, supportive and visible. Staff we spoke with told us there was good teamwork within teams and there was a culture of openness and honesty.
- Diagnostic imaging leaders encouraged and enabled staff to develop their own skills and knowledge, share good practice nationally, and improve the service.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Managers told us clinical validation had occurred on some waiting lists, for example in areas of ophthalmology. However, this had not occurred on all backlogs or waiting lists for appointments across the trust. This did not provide assurance that the risk to patients waiting for follow up appointments was being mitigated or clinical validation was being completed across specialities.
- Where refrigerator temperature checks showed deviation from the required temperature, the action was not always documented on the daily check log. Refrigerator temperature checks processes were changing during our inspection.
- Mandatory training compliance rates for diagnostic imaging staff for medicines management and resuscitation training were low.
- Duty of candour was not well understood across all staff groups; however, senior managers could describe the duty of candour.

However:

- There was a trust incident reporting system which was used by outpatients and diagnostic imaging services. Staff we spoke with were aware of how to report incidents.
- Areas we visited were visibly clean and tidy. Radiology departments were clean and hygiene standards were good. Radiology departments were clean and hygiene standards were good.
- Medicines checked were stored securely and medicines checked were found to be in date.
- Staff we spoke with were able to describe how they would report safeguarding concerns and told us they would seek advice from the trust safeguarding team or their manager if required.
- Patient records were completed and available. Records in outpatients were stored securely in electronic format.
- Actual staffing levels matched the planned staffing levels in general across radiology modalities and staff worked across all sites to ensure continuity of the service at times of greater demand.

Incidents

- The trust had an incident reporting system used for reporting incidents in outpatients and diagnostic imaging. Managers told us these were investigated by service leads and where a serious incident had occurred, managers appointed a member of staff to investigate the incident.
- Between March 2016 and February 2017, the trust reported no incidents which were classified as never events for outpatients and diagnostic imaging.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The trust reported no serious incidents (SIs) in outpatients and diagnostic Imaging, which met the reporting criteria set by NHS England between March 2016 and February 2017. However the service had an incident categorised as severe by the trust which occurred in ophthalmology. The information provided by the trust highlighted delay in treatment and lack of capacity to meet demand as a contributory factor to the incident. The trust had completed a summary review which included information such as contributory factors, root cause, lessons learnt and recommendations.
- Managers told us that if a serious incident occurred, this would be discussed at local team meetings and the local governance meeting. Managers told us they would conduct a 72 hour report on the incident and the risk committee would then decide if further investigation would be required.
- Staff we spoke with were able to describe how they report incidents through the online incident reporting system. Some staff told us they would seek advice on how to complete an incident report if they were required to.
- Staff told us they received learning from incidents through team meetings. Ophthalmology outpatients had regular monthly team meetings. Main outpatients did have team meetings; however, these were not always monthly.

- Staff understanding of duty of candour varied across the services, however staff could describe being open and honest.

Diagnostic imaging:

- The services reported no serious incidents (SI's) in outpatients between March 2016 and February 2017.
- All managers and most staff we spoke with were aware of duty of candour, their responsibilities and its requirements. Staff at all levels were able to explain their departmental culture of being open, honest and transparent when things go wrong.
- Radiology discrepancy incidents were discussed by case review with radiologists. Reporting radiographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to learn and work as a multidisciplinary team with referrers and clinical teams.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean. Staff adhered to bare below the elbow policy. Hand gel was available in areas visited and personal protective equipment such as gloves were available. Managers told us departments were cleaned daily.
- General outpatients frontline ownership (FLO) audit for Pontefract hospital showed general environment at 100%, patients immediate area was 100%, dirty utility and waste disposal was 100%, linen was 100%, storage areas and clean utility/treatment room was 100%. Hand hygiene facilities were at 100% and overall compliance for the FLO audit was 100% at Pontefract Hospital. Hand Hygiene compliance was 97% and bare below the elbows was at 100%.
- There were carpets in main outpatients, however clinic rooms did not have carpets. Managers told us these were cleaned when requested by outpatients. Information provided by the trust highlighted carpets were on a schedule for cleaning and included an annual clean, along with a weekly clean. Carpets were on the risk register for Pinderfields Hospital, However they were not on the risk register for Pontefract Hospital.
- We saw use of stickers highlighting equipment had been cleaned. These were displayed on different equipment in outpatients.

Diagnostic imaging:

- Personal protective equipment (PPE) such as gloves, masks and aprons was provided and used appropriately throughout the imaging department and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- Specialist diagnostic imaging protective equipment including lead aprons were provided and were clean and free from cracks. Staff explained the safety procedures undertaken to ensure aprons were checked for wear and tear or damage.
- The department was cleaned daily by a domestic staff member and we noted all areas we observed were clean.
- The department's different areas such as changing rooms and reception were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination.
- Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly.

Environment and equipment

- The trust undertook an outpatient survey in 2016. The survey had a response rate of 42%. The survey showed that 100% of respondents highlighted the toilets were clean and 99% reported that the environment was very or fairly clean.
- Main outpatients had two seating areas. Ear, nose and throat outpatients had a children's play area. Ophthalmology had a seating area and they placed leaflets on each seat for patients with information for patients on attending the clinic. Main outpatients had a vending machine in the waiting area.
- Equipment we checked had been portable appliance tested. Resuscitation trolleys were available in ophthalmology and main outpatients and had been checked and were up to date. There was a hypoglycaemic pack located in the department, this had a checklist to be completed daily; however, the checks had not been consistently documented on the checklist. We raised this with managers and they were going to address it.
- Ophthalmology outpatients had a bariatric seat available for use.

Outpatients and diagnostic imaging

- Staff told us the main outpatient department temperature could be warm, fans were used to assist in addressing this.

Diagnostic imaging:

- Check in was by receptionist at the main entrance to the department with a further reception for patients with direct access from the Emergency Department. The reception desks provided enough space between the desk and the people waiting to ensure patients could not be overhead speaking.
- X-ray equipment was well maintained and quality assurance (QA) checks were in place for all equipment. QA checks are mandatory and based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protect patients against unnecessary exposure to harmful radiation.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were within the acceptable range as set by IRMER.
- The department provided local rules for each piece of equipment and we saw a user guide for each room.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- Crash trolleys throughout the departments were all locked and tagged. We saw checklists to show staff made regular checks of contents and their expiry dates and all stock we checked was within its use by date.
- There was sufficient seating to meet demand. The department had designated trolley areas and wheelchair spaces. There were separate areas for inpatients and outpatients. This made sure that the privacy and dignity of patients was preserved.

Medicines

- Medicines checked were found to be in date and stored securely in locked cupboards. Staff told us they stock rotate as they replenish stock levels in the departments.
- Refrigerator temperatures were checked on the days the clinics were on, however when the temperature had been out of range, it was not always clear on the documentation whether this had been reported to pharmacy
  Staff told us the temperature check procedure was changing as the trust had implemented electronic temperature monitoring.

Diagnostic imaging:

- We found medicines to be managed securely and according to trust policies and practice. The medicines refrigerators were locked and the medicines we checked were in date.
- Records provided by the trust showed that only 52% of all diagnostic imaging staff had attended Medicines management level two training. No staff in CT had attended medicines management level one training. However, records showed that 31 staff had been identified as needing this training.

Records

- Records were written during clinics and scanned onto the electronic patient system. Staff told us there were no current concerns with record availability in outpatients. Records in main outpatients were stored in trolleys behind reception during the day and staff told us these were not left unattended. Staff told us records kept in the department overnight for the next clinic were stored in a locked room.
- As of April 2017, the trust reported there were no known instances of patients seen in outpatients without their full medical record being available. The trust has reported that they mitigate this by having a standard operating procedure in place.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically and available to clinicians across the trust via electronic records systems.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were stored electronically and were easily accessible to all diagnostic imaging staff.

Outpatients and diagnostic imaging

Safeguarding

- The trust target for completion of mandatory safeguarding training was 95%.
- Medical and dental staff within the Outpatients and Diagnostic core service did not reach the 95% compliance rate for any of the safeguarding courses.
- Nursing and midwifery staff within the outpatients and diagnostic core service achieved the 95% compliance rate for safeguarding adults level one and safeguarding children level one. They also met the target of 85% for safeguarding children level two and safeguarding adults level two.
- Staff told us they would contact the trust safeguarding team for advice and seek advice from their manager if required.

Diagnostic imaging:

- Staff had a good understanding of safeguarding vulnerable adults and children principles and processes. Staff we spoke with knew that there was a policy on the intranet and staff within the organisation who they could speak with for advice.
- Radiology training compliance for all staff across the trust was close to the trust target at 92% for Safeguarding adults level 1 and 88% for level 2. For safeguarding children training the compliance rates were 92% for level 1 and 90% for level 2.

Mandatory training

- Staff told us they were mostly up to date with their mandatory training and staff that had not completed all mandatory training were booked on to complete the required courses. Managers in physiotherapy outpatients told us that during the inspection the mandatory training completion rate was 90.6%. Cardiology outpatients mandatory training compliance rate was 95% during our inspection.
- The trust set a target of 95% for completion of mandatory training, which the trust class as core: diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children.
- Nursing and Midwifery staff within the outpatients and diagnostic imaging core service achieved the target for five of the seven core training modules; they did not reach the target of 95% for Infection control and fire safety.
- Medical and Dental staff within Outpatients and Diagnostic imaging core service achieved the target for three of the seven core training modules; they did not reach the target of 95% for infection control, fire safety, health and safety and information governance.

Diagnostic imaging:

- Staff we spoke with confirmed they had attended mandatory training. Managers had access to an online system to identify staff mandatory training completion rates and would use this system to ensure staff had completed or were booked on mandatory training.
- However, managers we spoke with told us, and records showed, mandatory training compliance rates did not achieve the trust target of 95%.

Assessing and responding to patient risk

- Staff told us if a patient deteriorated in clinic, they would request help and call the emergency team if required.
- There were backlogs in ophthalmology outpatients for first and follow up appointments. Managers told us that Glaucoma patients had an administrative validation to check they were on the correct waiting list followed by a consultant validation. The Glaucoma service had two forms, one was the partial booking referral form which went to reception staff and the booking centre to book an appointment and there was another referral form which was used for appointments which had to be booked in the following 12 weeks. The 12 week form for appointments was used to ensure the appointment was booked within the required timeframe. There was no clinical validation in other ophthalmology appointment backlogs. Ophthalmology clinical governance meeting minutes for May 2017 highlighted patients not receiving appointments for requested time due to ongoing capacity issues as a risk.
- Managers told us there were no issues with first appointments for the macular unit and for the first 12 months of treatment, however after 12 months there was a six week additional wait for follow up appointments.
- Managers told us some waiting lists had been clinically validated, however not all had been. The planned care

improvement programme plan had clinical validation and review of follow ups as part of the plan and stated that review and validation of follow up patients was in progress as at February 2017.
- The follow up project plan highlighted review and validate follow up backlog. Most actions were in progress.
- The trust provided a document which was an update on the management of patients waiting for follow up in April 2017 and this highlighted the trust could not provide assurance that clinical validation had or was taking place across specialities.

Diagnostic imaging:

- Diagnostic imaging policies and procedures were written in line with (IR(ME)R) to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) were employed by the trust. They visited the departments, attended meetings and provided advice as required.
- There were named certified Radiation Protection Supervisors (RPS) for each modality to give advice when needed and to ensure patient safety at all times.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000). Local rules for each piece of radiological equipment were held electronically and available to all operational staff within the immediate vicinity of the equipment.
- The department had a process for prioritising the urgency of diagnostic imaging referrals and requests. All urgent referrals were flagged and escalated to ensure they were given an early appointment. All other requests were triaged and appointments were allocated accordingly.
- We observed and records showed diagnostic imaging staff used the world health organisation (WHO) safer surgical checklist for all interventional procedures. The latest audit of WHO checklist compliance for February 2017 showed 100% compliance for fluoroscopy, angiography and cardiography. A wider audit carried out at the same time for all procedures within diagnostic imaging showed 89% compliance.
- Managers told us that the WHO safer surgical checklist process had been adopted and embedded by all staff carrying out interventional procedures and we saw an audit carried out in April 2017 showed compliance rates between 85% and 90%. Staff told us checks were always completed in practice and full compliance would be achieved with improved documentation.
- Staff told us that the risks of undergoing an x-ray whilst pregnant were fully explained to patients. Electronic records we saw showed that staff had checked no woman of childbearing age was at risk of having an x-ray taken if there was a chance she may be pregnant. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not.
- Resuscitation training compliance for all diagnostic imaging staff across the trust was only 68%.

Nursing staffing

- As at March 2017, outpatient's whole time equivalent (WTE) staffing establishment at Pontefract Hospital was 13.79 WTE. There were 12.71 WTE in post.
- As at 28 February 2017, the trust reported a vacancy rate of 11% in outpatients for qualified and unqualified nursing staff. Pontefract General Hospital had a vacancy rate of 8%.
- Between March 2016 and February 2017, the trust reported a turnover rate of 10% in Outpatients for qualified and unqualified nursing staff. Pontefract General Hospital had a turnover rate of 10%.
- Between March 2016 and February 2017, the trust reported a sickness rate of 7% in Outpatients. Pontefract General Hospital had a sickness rate of 7%.
- There was no data available for bank and agency use within outpatients and diagnostic imaging across the trust.
- Managers told us recruitment to administrative posts was difficult and they had previously held a recruitment drive to try and address this issue.

Outpatients and diagnostic imaging

- Managers and staff told us there were no concerns with nurse staffing levels in outpatients. Staff were able to work across hospitals at the organisation to support outpatients where required. Staffing rotas were managed and organised by the department managers.
- Pontefract Hospital had a planned staffing WTE level of three with an actual WTE staffing level of three staff.
- Physiotherapy staffing levels provided by the trust for April 2017 showed there was a planned WTE staffing level of 61.92 for qualified staff and the service had an actual WTE staffing level of 59.18.
- The trust provided information stating that Audiology outpatients had a planned WTE was 24.84 and the actual WTE was 23.67; however the information provided by the trust stated they had recently recruited and had full establishment as at June 2017.
- The trust provided information on ophthalmology outpatient staffing vacancies. This showed that the trust had one WTE Band six Nurse Practitioner, 43 hours Band five and 1.7 WTE Band three. There was one consultant post vacancy and two specialist optometrist post vacancies.

Diagnostic imaging:

- The trust had appointed a radiology matron who acted as direct line manager for radiology nurses.
- There was a Band 6 radiology sister and a team of 14 specialist nurses to support interventional radiology procedures. There were four whole time equivalent (WTE) nursing vacancies. However, one new Band five nurse had been recruited and was due to commence shortly after our inspection.
- Interviews for Bands two and three support staff were planned for early June 2017.
- Most interventional work was carried out at Pinderfields General Hospital but nurses travelled between hospitals to support interventional procedures.

AHP Staffing

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiographers, clinical support workers, and nursing staff to ensure that patients were treated safely.
- Between March 2016 and February 2017, the trust reported a sickness rate of 3.6% for radiology staff.
- There had been difficulties in recruitment of qualified radiographers in the past. This was in line with the national picture regarding radiographer recruitment. There had been significant vacancies across the team and managers told us these had improved significantly. The establishment figure for radiographers across the whole trust was 169 WTE staff and at the time of our inspection there were 149 in post. The vacancy rate was 7.5% and these posts were being recruited to following successful recruitment open days targeted at final year students. Staff we spoke with were able to corroborate this.
- The departments had three agency staff and only five bank staff across the whole trust. Bank and agency staff completed the same induction processes as substantive staff.
- Managers were planning for new staff to be trained to specialise in modalities including CT.
- The radiology department had nurses and clinical support workers who assisted with interventional procedures.
- Sonographers reported their own ultrasound scans at the time of each procedure. A lead sonographer was responsible for ultrasound across all sites.

Medical staffing

- Between March 2016 and February 2017, the trust reported a turnover rate of 17% in Outpatients for permanent medical and dental staff.
- Between March 2016 and February 2017, the trust reported a sickness rate of 1% in Outpatients for permanent medical and dental staff.
- There was no data available for bank and agency use within outpatients and diagnostic imaging across the trust.
- Managers told us there were no known concerns with medical staffing in main outpatients.

Diagnostic imaging:

- The department contracted the reporting of some overnight plain film X-rays to external companies to enable them to meet the demands on the service. There were formal service level agreements (SLA) in place for this process. Trust radiologists followed the quality assurance process to report discrepancies back to outsourcing companies.

Outpatients and diagnostic imaging

- There was a national shortage of radiologists. However, this trust experienced no difficulties in recruitment to consultant or specialty training grade posts. There were 28 WTE consultant posts and 27 of these were filled.
- There was consultant cover across the trust out of hours and at weekends.
- At the time of this inspection, the trust had a full establishment of consultant radiologists. The trust employed ten specialist radiology trainees who were completing placements with the trust. There was only one vacant post.
- At the time of this inspection, there were sufficient staff to provide a safe and effective service.

Major incident awareness and training

- Managers and staff we spoke with told us they would follow the major incident policy at the trust if a major incident occurred. Staff told us this was accessible on the intranet in the services.
- The trust had a major incident procedure in place.
- The access, choice and booking centre had business continuity plans in place in the event of information technology failure within the booking centre.

Diagnostic imaging:

- Staff were aware of the action they should take in the event of a radiation incident. There were standard operating procedures in place.
- The diagnostic imaging department had business continuity plans in place. There were maintenance contracts in place to ensure that any mechanical breakdowns were fixed as quickly as possible.
- Staff knew their roles in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate effective, however we found:

- Staff we spoke with were able to describe the National Institute for Health and Care Excellence (NICE) guidelines they used and departments visited, such as diabetes and physiotherapy outpatients, used goal setting for patients.
- Diagnostic imaging staff we spoke with could describe the national guidance they used. Staff had undertaken extensive further training and development to develop further competency and skills in their work.
- Radiologists, radiographers and specialist nurses undertook clinical audits to check practice against national standards and to improve working practices.
- There were multi-disciplinary team (MDT) meetings in several specialties across diagnostic imaging and radiologists were included in MDTs throughout the Trust.
- Between December 2015 and November 2016, the follow-up to new rate for Pontefract General Infirmary, Dewsbury and District Hospital, and Pinderfields General Hospital was lower than the England average.
- The trust reported that between April 2016 and March 2017 Mental Capacity Act (MCA) and Deprivation of Liberties level 1 training had been completed by 100% of staff within outpatients.
- Consent given by the patient was recorded and we saw examples of consent recorded in patient records.
- Staff knew the various policies to protect patients and people with individual support needs. Staff in diagnostic imaging asked patients for their consent before treating them. Staff were clear about how to support patients when they lacked, or had changes in, mental capacity.

However:

- Appraisals completion rates did not always achieve the trust target.

Evidence-based care and treatment

- Staff in diabetes outpatients told us the guidelines used were based on National Institute For Health and Care Excellence (NICE) and there had been a multi-disciplinary team (MDT) meeting a year ago to review these. Diabetes outpatients participated in a number of audits, for example a high impact audit and frontline ownership audit.
- Goal setting was in use in services such as diabetes outpatients and physiotherapy service for patients receiving care.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.

- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with ionising radiation undertaken in the trust was safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to lead on the development, implementation, monitoring and review of the policy and procedures to comply with (IR(ME)R).
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.
- Consultant radiologists told us and we observed audits to show they used a WHO checklist for every interventional radiology procedure. These were audited and compliance rates showed consistent improvement.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Nutrition and Hydration

- Water dispensers were not available in outpatients. Staff had raised this as an issue and managers were considering ways to address this. The outpatient department had food and drink machines available for patient use.

Diagnostic imaging:

- Water fountains were provided for patients' use in waiting areas and there was a café nearby where people could purchase drinks and snacks.
- Nurses could provide hot and cold drinks and snacks or small meals for patients undergoing interventional procedures and for those with long waits for transport.

Pain relief

- Pain scores were used in physiotherapy outpatients and staff completed checklists for equipment where required to help with pain relief.

Diagnostic imaging:

- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures.

Patient outcomes

- Between December 2015 and November 2016, the follow-up to new rate for Pontefract General Infirmary, Dewsbury and District Hospital, and Pinderfields General Hospital was lower than the England average.
- Physiotherapy outpatients used a questionnaire to assess patient outcomes and collected this data quarterly. This was in progress during our inspection. Staff told us they provided a back to activity exercise class and patient outcomes were reviewed when patients were discharged.

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- The radiology quality assurance programme including radiology audits were led by lead radiographers for each modality across the trust.

Competent staff

- Data provided by the trust on appraisal completion rates could not be split by hospital site level. All staff groups were below the trust target of 85% for appraisal completion except for medical and dental staff groups which were at 92.6% against a target of 91.5%. Additional clinical services were at 84% allied health professionals were at 83% nursing and midwifery staff group was at 82% Scientific and technical group were at 50% and administrative and clerical were at 71%. Managers in outpatients told us that where appraisals had not been completed, staff were booked in to complete these.
- Managers in physiotherapy outpatients told us that appraisal compliance was 88% against a target of 85%.
- The access, booking and choice directorate had a team leader programme available for staff to attend to develop team leading skills and knowledge. Managers told us this enabled staff to develop within the service. The directorate also had access to a trust programme to help leaders and managers develop in their roles.

Outpatients and diagnostic imaging

- Staff we spoke with told us they had annual appraisals and these were an opportunity to discuss training. Staff in outpatients worked between the different clinics in outpatients to ensure they could cover when required and gain experience in different clinic specialities. Staff we spoke with had opportunities to develop further and attend courses relevant to their practice.
- The ophthalmology service had converted some posts in the service into nurse specialist's posts and a specialist optometrist post to assist in addressing medical staffing challenges in the speciality. Ophthalmology held nurse led clinics. Some staff had completed an ophthalmology nursing qualification and completed further in house training, for example in nurse specialist injections.

Diagnostic imaging:

- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Allied health professionals were supported to maintain their registration and continuous professional development.
- Radiology staff were assessed against radiology competencies and training for working with equipment was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal and specific modality training.
- Students were welcomed in all departments. Radiography students came for elective placements and managers told us they had recruited new graduates from their student cohorts.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers had been trained for lead roles in each modality including CT and MRI.

Multidisciplinary working

- Staff worked with different professions such as doctors, registered nurses, occupational therapists, physiotherapists and healthcare assistants.

Diagnostic imaging:

- There was evidence of multidisciplinary working in the imaging department. For example, nurses, radiographers and medical staff worked together in interventional radiology within the department, other specialty clinics and in theatres.
- We saw that the diagnostic imaging departments had links with other departments and organisations involved in patient journeys such as GPs and support services. For example the radiology department worked with the Accident and Emergency department to ensure that X-rays, CTs and other scans were carried out and reported in a timely manner.
- Radiologists attended multi-disciplinary meetings across several specialties to discuss diagnosis and treatment plans for patients including those with suspected cancer.

Seven-day services

- Outpatients offered appointments between Monday and Friday between 8:30am and 5pm.There were additional clinics during weekends where there was demand for the services.

Diagnostic imaging:

- Diagnostic imaging services including plain film, CT, and MRI were available 24 hours seven days a week for trauma and inpatients. Ultrasound was available on weekdays and in the mornings at weekends. Radiographers and clinical support workers were on site providing overnight cover, with further on-call support available if necessary.
- Outpatients and GP patients could attend for x- rays seven days a week and up to 8pm on weekdays. When demand increased the department could flex staffing to provide sufficient imaging sessions.

Access to information

- Staff had access to computers and a trust intranet. The electronic reporting systems could be accessed from the intranet and staff told us they had access to records as required through the computer systems.
- Staff we spoke with told us they received regular communication bulletins. Information was also available on the trust intranet for staff.

Diagnostic imaging:

Outpatients and diagnostic imaging

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, and medical records appropriately through electronic records.
- Diagnostic imaging departments used a picture archive communication system and a computerised radiology information system to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make.
- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.
- Diagnostic results were available through the electronic system used in the department. These could be accessed through the system available in wards and clinics throughout the trust.
- Senior staff organised daily huddles to ensure all staff were available to discuss the day ahead and raise anything that would benefit staff and managers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that between April 2016 and March 2017 Mental Capacity Act (MCA) and Deprivation of Liberties level 1 training had been completed by 100% of staff within outpatients.
- Consent given by the patient was recorded and we saw examples of consent recorded in patient records.

Diagnostic imaging:

- Diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Audit of the WHO safer surgical checklist carried out at all interventional procedures across the trust showed good compliance that was consistently improving. The current compliance rate was 90%.
- Training compliance rates for diagnostic imaging staff across all modalities for Mental Capacity Act and Deprivation of Liberty Safeguards level 1 training was 93% and but was lower, at 80% for level 2.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We found staff to provide compassionate care to patients in outpatients and diagnostic imaging and provide additional support where required. Chaperones were available to support patients in outpatients and diagnostic imaging.
- Privacy and dignity was maintained by staff in areas visited.
- Friends and family test (FFT) data was positive for outpatients.
- Specialist registered nurses were available in a number of services visited.

Compassionate care

- We found staff to provide compassionate care to patients and provide additional support to patients where required in clinics. Chaperones were available in clinics.
- Staff told us they ensure patient privacy and dignity is maintained whilst in clinic through ensuring clinic doors are always closed and clinic curtains are used when required.

- Patients we spoke with were positive about the services they had visited.

Diagnostic imaging:

- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the departments.
- Staff ensured that patients felt comfortable and safe in the department and we observed them putting patients of all ages at ease.
- There were gowns available to patients to maintain their dignity and, although these were always offered, we observed some patients preferred not to use them.
- There were designated areas for patients on trolleys to maintain their privacy.
- The department had been designed to provide as much privacy and dignity as possible with changing rooms and toilets close to procedure rooms and away from public thoroughfares. However staff working in the recovery area told us the environment may not always allow for total privacy and confidentiality but staff worked carefully to maintain this as much as possible.
- We spoke with two patients and two people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Understanding and involvement of patients and those close to them

- Friends and family test data for October 2016 for the outpatients department showed that 97.1% were likely to recommend and in November 2016, 96.6% were likely to recommend the service. The response rate was below the 20% target during these months.
- Staff told us first appointments were longer than follow up appointments which allowed patients to ask questions regarding their care and treatment.
- Staff in physiotherapy outpatients discussed outcome goals with patients.

Diagnostic Imaging:

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by staff. All those we spoke with told us that they knew why they were attending for a procedure or scan.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment. We observed examples in diagnostic imaging where staff gave patients and families' time and opportunities to ask questions.
- Radiology reception was situated near to the department entrance and staff frequently checked the entrance areas for trauma and inpatients to greet people and assist them where required. Staff we spoke with described examples where they would provide further support to patients if required.

Emotional support

- Clinical nurse specialists were available in a number of clinics. Ophthalmology had nurse led minor operation clinics.

Diagnostic Imaging:

- Staff told us that on request, if someone was anxious about a procedure such as a scan, they could visit the department first to look at the equipment and understand what to expect. This was also available for patients living with a learning disability. A patient had an appointment on the day of our inspection and had been offered a chance to look around the department and also to take the first appointment so that the department was quiet and there would be a reduced chance of any delays.
- There was a process in place to support patients living with dementia or a learning disability who needed extra support in the scanning or x-ray room. A carer or relative could be in the x-ray room, protected by a lead apron to ensure that the patient felt safe

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- No specialties were above the England average for non-admitted referral to treatment (RTT) (percentage within 18 weeks).

Outpatients and diagnostic imaging

- Between February 2016 and January 2017, the trust's referral to treatment time (RTT) for incomplete pathways had been worse than the England overall performance and worse than the operational standard of 92%.
- The trust has performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral since Q1 2016/17.
- Follow up appointments dates to be seen were not always met by the services in outpatients. There were patients waiting for appointments past their see by date.
- There were 19,647 patients in the trust backlog waiting for appointments which included first and follow up. This backlog of patients waiting for appointments had deteriorated since the last inspection.
- The trust measured turnaround times in a different way from Keogh standards. They measured time taken from referral to report rather than referral to image and a separate measurement of image to report. Although measured differently, trust and national targets were not consistently met.

However:

- The trust did have referral to treatment recovery plans in place for specialities at the trust which were used to highlight current performance data and the current position of the speciality in relation to the RTT indicators, along with actions being taken and an action plan tracker. These plans had been developed to address the current issues with waiting lists and referral to treatment indicators.
- The trust had a trajectory to be achieving the indicators by March 2018.
- The Did Not Attend (DNA) rate was lower than the England average.
- The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- The trust is currently performing slightly better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).

Service planning and delivery to meet the needs of local people

- Managers told us that capacity and demand in the service was planned within the services and as part of the annual planning cycle.
- Outpatients offered appointments between 8.30am and 5pm, Monday to Friday and would add clinics on a Saturday where there was demand. Patients would check in at main reception of the hospital where there were electronic check in desks. Patients were then directed to the appropriate outpatient clinic when required.
- The booking centre was responsible for booking outpatient appointments in a number of services such as medicine and surgery. Partial bookings were also made by the booking centre and the booking centre took calls from patients regarding outpatient appointments. Ophthalmology outpatients partial bookings were carried out by the booking centre and all other appointments were booked by the ophthalmology outpatient clinic.
- Between December 2015 and November 2016, the 'did not attend rate' for Pontefract General Infirmary, Dewsbury and District Hospital, and Pinderfields General Hospital was lower than the England average.
- Areas visited had cards such as yes and no cards to support patient's where additional support and assistance was required. The services used a VIP card which had information about patients attached and could be shown to staff upon arrival at the services. Staff told us they could contact the acute hospital liaison nurse for learning disabilities if needed for advice.

Diagnostic imaging:

- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and scanning sessions were arranged to meet patient and service needs.
- Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements. Urgent reports were flagged for prioritisation.

Access and flow

- The backlog of patients waiting for first and follow up appointments across the trust outpatient departments had deteriorated since the last inspection and

information provided by the trust showed at the end of March 2017 there was a backlog of 19,647 patients who had waited over three months for a follow up appointment.

- There were patients overdue their appointment by three months in different specialities across outpatients. Ophthalmology had the largest backlog of patients overdue their appointment by three months with 6942 patients waiting; this was followed by trauma and orthopaedics with 2512 patients and gastroenterology with 1382 patients overdue for their appointment.
- Ophthalmology outpatient managers told us they had a backlog of patients waiting to be seen in outpatients. Managers told us there were no current issues with the macular clinic and first appointments followed by the first 12 months treatment; however, after the first 12 months there was a delay in follow up appointments of around six weeks. Ophthalmology was at 68.1% for non-admitted RTT (percentage within 18 weeks) against an England average of 92.1%. Ophthalmology was at 79.6% for incomplete pathways RTT (percentage within 18 weeks) against an England average of 92.3%.
- Managers told us there were particular challenges around first appointments, follow up appointments and appointments in the surgery directorate. Managers told us that a number of specialities had long waits for appointments. Each speciality had an action plan to address waiting lists and referral to treatment indicators. Managers told us demand was high and there had been consultant vacancies across different specialities. The services were trying to address this by working with other qualified providers, putting extra clinics on and job planning. Managers also told us of their aim to make the services sustainable.
- The trust provided us with RTT recovery plans for specialities such as rheumatology, dermatology, ENT and ophthalmology. These recovery plans included performance information such as the current position of speciality and the action being taken along with an action plan tracker. These RTT recovery plans had been developed to address the current issues with waiting lists and RTT indicators.
- Addressing the backlog of outpatients appointments, including follow ups and ensuring clinical deteriorations in a patient's condition are monitored and acted upon for patients who are in the backlog of outpatient appointments was part of the improvement plan from the previous inspection, however this was still in progress during the inspection.
- Managers told us there had been no 52 week breaches for waiting times and the maximum wait for a first appointment was between 28 and 38 weeks in some specialties.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for January 2017 showed 76.9% of this group of patients were treated within 18 weeks versus the England average of 89.3%. There has been a downward trend in performance over the last 12 months.
- No specialties were above the England average for non-admitted RTT (percentage within 18 weeks). Data showed that the lowest percentage was ENT with 64.8% for non-admitted RTT against an England average of 90.3% and the highest percentage was rheumatology with 89.2% performance for on-admitted RTT against an England average of 92.1%.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for incomplete pathways had been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for January 2017 showed 80% of this group of patients were treated within 18 weeks versus the England average of 89.7%.There has been a downward trend in performance over the last 12 months.
- No specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks). Data showed that the lowest percentage was ENT with 72.8% for incomplete pathways RTT against an England average of 89.6% and the highest percentage was geriatric medicine with 93.8% performance for incomplete pathways RTT against an England average of 96.9%.
- The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- The trust is currently performing slightly better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- The trust had performed worse than the 85% operational standard for patients receiving their first

treatment within 62 days of an urgent GP referral since Q1 2016/17.Managers told us the 62 day operational standard performance was variable; the trust met the standard in February 2017, did not meet it in March 2017 and met the standards in April 2017.

- The percentage of clinics cancelled within six weeks in November 2016 was 4.9%, in December 2016 was 5.3%, in January 2017 was 5.8% and in February 2017 was 5.4%. The percentage of clinic cancelled over six weeks in November 2016 was 6.3%, in December 2016 was 6.4%, in January 2017 was 7.8% and in February 2017 was 6%. The main reason(s) for cancellations as reported by the trust are: over six weeks: annual leave, on call, study leave and under six weeks: sickness, non-compliance with process by specialty resulting in late notification. Managers told us clinics were sometimes cancelled within six weeks.
- The service did not monitor the length of time patients waited in clinics once they had arrived for their appointment. However on a daily basis staff would highlight in clinic waiting times on the waiting room information boards and would inform patients as to delays in the service on a daily basis. Staff informed patients of delays after 30 minutes of delay in clinic.
- Managers told us the booking and call centre had a target of 95% to answer calls within three minutes. Data from the booking centre between 6 and 10 March 2017 showed that 97% of calls were answered within three minutes.
- The trust undertook an outpatient survey in 2016. The survey had a response rate of 42%. The survey showed that 29% of respondents highlighted that the appointment started more than 15 minutes after stated time. 49% of respondents stated that nobody apologised for the delay when waiting to be seen. The survey report provided by the trust showed that 99% of people were able to find a place to sit in the waiting room.
- The survey highlighted that patients not being told what would happen next had worsened since the last survey in 2011 with 13% of patients not told what would happen next in 2016.
- Outpatients had an outpatient follow up procedure in place with a review date of February 2019.
- Pathology testing turnaround times were measured on a monthly basis and almost always met national expected timescales. They were rarely rated below trust targets.

Diagnostic imaging:

- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and seven working arrangements. They monitored waiting times and were able to identify any possible breach dates. This enabled the team to take action such as adding extra appointments. They organised imaging sessions and staff to accommodate urgent diagnostic imaging requests.
- Managers told us that they worked closely with staff from other departments and specialties on their performance in providing a good and prompt service to meet targets. These included Accident and Emergency imaging and reporting as well as timely imaging for specialties to support referral to treatment targets and urgent cancer referrals.
- Patients referred by their GP for plain film x-rays could attend without an appointment. GP patients made up 29% of all patients attending for x-rays.
- The Trust Performance dashboard showed that compliance for diagnostic results exceeding referral to test six week target ranged from 0% and 0.04% in the six months from August 2016 to January 2017. However, national data showed that between February 2016 and January 2017 the percentage of patients waiting more than six weeks for a diagnostic test was generally higher than the England average. The latest figures for January 2017, showed 2.9% of patients waiting more than six weeks versus the England average of 1.7%. There has been fluctuation in performance over the last 12 months; figures were higher than the England average between February 2016 and July 2016, lower than the England average between August 2016 and November 2016 before rising back above the England average for the latest two months (December 2016 and January 2017).
- Radiology managers told us, and the quality dashboard confirmed, diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals for inpatients and emergency department referrals met national targets. Compliance for inpatient and emergency department referrals was met in no less than 99.98% across the department in the last 12 months.
- The percentage of images taken and reported across all modalities for two-week cancer target was 76% and a trust based target of three weeks from referral to report was 85%. This included CT, MRI, ultrasound and plain

film x-rays. This did not meet Keogh standards for reporting times. However, staff told us that the demand for urgent cancer referrals had doubled since June 2016 and one third of all CT referrals were 'fast track' requests, which meant they were given priority over all other requests.

Meeting people's individual needs

- A number of services visited had patient information leaflets on display for patients, for example ophthalmology had patient information leaflets in waiting areas.
- Physiotherapy had a separate service dedicated to learning disability patients. Physiotherapy outpatients had also recently increased the length of assessment times.
- The trust used VIP cards which held information about the patient and could be presented to staff upon arrival at clinics. These cards could be used by patients with a learning disability attending the services. Additional communication cards such as yes and no cards were available for staff to use to assist patients attending the services.
- Staff told us they had access to interpreter services.
- Staff at the booking centre told us letters that were sent to patients included the contact details of the booking centre staff they could contact for further information and advice.

Diagnostic imaging:

- Patients with complex individual needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.
- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
- Bariatric equipment was available and accessible.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Patient information leaflets were plentiful, of good quality and up to date.
- Staff told us interpreter services were available across outpatients and diagnostic services. Staff gave an example of how an interpreter had provided a flexible service when an appointment had to be rearranged.

Learning from complaints and concerns

- Between March 2016 and February 2017 there were five complaints about Outpatients. The trust graded all five as 'Low'.
- In the same time period there were 40 complaints about Radiology, they were graded high (one), medium (nine) and low (30).
- Managers in outpatients told us there had been no complaints at Pontefract Hospital outpatients in the last 12 months.
- The trust provided seven access, booking and choice complaint action plans. These highlighted the complaint, action and the person responsible along with due dates for completion.

Diagnostic imaging:

- Staff in diagnostic imaging told us that informal comments and complaints were few and far between and none of the patients we spoke with had ever wanted or needed to make a formal complaint.
- There were patient information and advice stations located in the main entrance, near to the diagnostic imaging department.
- Volunteers made themselves available to all visitors to the hospital to help them find their way and to access any help they needed.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at team meetings, actions agreed and any learning was shared.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Good

We rated well-led as good because:

- Managers were able to describe their focus around addressing issues with the referral to treatment indicators and addressing waiting times. Managers told us they had recovery plans in place and attended weekly performance management meetings for RTT and waiting lists. Managers told us they were able to escalate any issues from the performance management meeting directly to senior management at the trust.
- The services had risk registers in place which were reviewed monthly. Managers were aware of the risks across the service such as RTT issues. Risks were escalated to divisional governance meetings which could then be escalated further if required.
- Most staff we spoke with told us managers and team leaders were available, supportive and visible. Managers told us they had an open door policy. Most staff told us communication had recently improved. Staff we spoke with told us there was good teamwork within teams and there was a culture of openness and honesty.
- The services had carried out different engagement with staff and the public through staff surveys and friends and family test. Staff bulletins were in use across the services to improve engagement.
- Diagnostic imaging leaders encouraged and enabled staff to develop their own skills and knowledge, share good practice nationally, and improve the service.

However:

- In main outpatients, team meetings were did not always happen monthly. Managers were aware of this and told us they were addressing consistency of team meetings in main outpatients.

Leadership of service

- Services were managed by local service managers. There had been a recent change in structure to the directorates and outpatients had a new senior role managing across the service which had been implemented to assist in developing professional support to the services.
- The access, booking and choice directorate managed most outpatient services; however, ophthalmology and physiotherapy outpatients were part of their own directorate.
- Most staff we spoke with told us managers and team leaders were available, supportive and visible. Managers told us they had an open door policy. Staff told us communication had recently improved.

Diagnostic imaging:

- Staff were very positive about local leadership and we were told managers made themselves available and approachable.
- The trust had employed lead radiographers for each modality to lead the teams across all sites to ensure safe and effective working practice, a skilled workforce, and quality assurance.
- Staff told us diagnostic imaging department leadership felt stable, reliable, and was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train staff.
- Departmental managers were supportive in developing the service and practice, and the trust as a whole valued its staff. Staff felt that they could approach managers with concerns and feel listened to. We observed good, positive and friendly interactions between staff and managers.
- Staff told us they saw the group management team regularly.
- Managers told us that IR(ME)R incidents were looked on as an opportunity to learn.
- The radiology matron provided nursing leadership for interventional radiology and the wider team. They took responsibility for infection control and medicines management within all radiology departments and modalities across the trust.
- Clinical leads and radiology managers collaborated to achieve shared goals including research and learning, development of advanced practitioners, and direct access pathways.

Vision and strategy for this service

- Outpatient managers told us their focus during the inspection was addressing the issues with referral to treatment indicators and this was being actioned through the joint planned care improvement group. The joint planned care improvement group was formed in

November 2016 and the group aims to improve performance in the key performance indicators (KPI's) relating to planned care and to implement transformational schemes.
- Diagnostic imaging services had a vison for the service. This was to deliver a nationally recognised excellent radiology service of a high quality exceeding national targets.
- The access, booking and choice service managed the outpatient services and the service was part of the surgical directorate.
- Outpatients displayed their mission statement in the reception of outpatients.

Diagnostic imaging:

- Diagnostic imaging services were provided across the three hospital sites at the trust.
- The diagnostic imaging department staff at all levels told us they were kept informed and involved in strategic working and plans for the future.
- The management team were working on ensuring that the department was able to cope with current and future demands on services. This involved the purchase of further MRI and CT machines.
- Improvements to the service were made to improve timely access for patients through radiographer vetting of referrals. Staff told us this practice saved one WTE consultant radiologist time.

Governance, risk management and quality measurement

- The outpatients department had a risk register which contained a number of identified risks to the services in outpatients. Managers told us the risk register was reviewed monthly. Managers told us the main risks identified in outpatients were referral to treatment indicators, cancer appointment indicators and follow up appointments, administrative staffing, the environment in some areas along with space issues and IT equipment. The risk register had one identified major category logged risk, this related to ophthalmology and meeting the four week standard for seeing patients. This risk was to be reviewed in March 2017.
- Managers we spoke with were aware of issues around referral to treatment targets and capacity and demand issues across the outpatients at the trust. Each week there was a performance management meeting to discuss waiting times and RTT. Managers told us they were able to escalate any issues from the meeting directly to senior management at the trust.
- Managers told us governance and risk issues were escalated through different meetings to board level if required. There were divisional governance meetings which were able to escalate risks through to the surgical directorate which outpatients were part of and risks identified would be escalated to the quality committee. Managers in outpatients told us they attended governance meetings and would enter risks identified onto the services risk register.
- There was an access, booking and choice governance group and the agenda from January 2017 showed that patient and public experience, safety and quality were on the agenda. The meeting minutes from December 2016 showed that the access, booking and choice governance meeting included complaints and action plans, compliments and patient stories, risks, clinical incidents and root cause analysis were part of this meeting.
- The access, booking and choice directorate held a governance meeting and presented quarterly to the surgical meeting. The surgical meeting had presentation at the trust quality committee which could escalate governance issues to the trust board.
- Physiotherapy services had introduced quarterly meetings in the last 12 months for care closer to home services.

Diagnostic imaging:

- The department had a risk register. Risks were rated high, moderate and low. These had been reviewed regularly. There was evidence of mitigation in place and action taken to reduce risks to patients.
- Diagnostic imaging had a separate and additional risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads and radiology protection specialists.
- Serious incidents were discussed at clinical governance meetings and where appropriate, escalated through the governance committees.
- Department managers carried out investigations of incidents and reported back to teams. Where necessary, policies and procedures were updated in line with guidance received.

Outpatients and diagnostic imaging

- There were governance arrangements which staff were aware of and participated in.
- Staff told us they understood the management and governance structure and how it reported up to the executive board and back down to staff with lessons learned across the trust.
- Consultants told us they took part in radiology reporting discrepancy meetings. These were held to discuss the quality of images and reporting. This forum was used to promote learning.
- In diagnostic imaging radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the group manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included guidance around specialist interventional and biopsy procedures.

Culture within the service

- Staff told us there was good team work within the teams and there was good support from managers. Most staff told us they felt respected and valued.
- The services used staff survey to gather feedback from staff and managers told us they had increased engagement with staff to assist in improving morale in the service.

Diagnostic imaging:

- All staff we spoke with told us they felt respected and valued. Staff we spoke with enjoyed their role and were proud of the service they provided. Staff told us there was good team work and that teams were supportive. Morale had improved significantly with improved trust senior leadership and staffing shortages in the service were also improving.
- Some staff we spoke with told us they had attended national conferences, training relevant to their practice and they shared information gathered with the team.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation.
- Staff were passionate about their work, and in particular their patients, and felt that they did a good job. Staff we spoke to in all the diagnostic imaging departments said that they felt part of a team and were empowered to do the job to a high standard.
- Diagnostic imaging staff told us there was a good working relationship between all levels of staff. We saw that there was a very positive, friendly and professional working relationship between managers, consultants, nurses, radiographers and support staff.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice at any level within their individual modalities.
- The department had a full time research radiographer and three other staff were seconded with external funding to carry out part time research.

Public engagement

- Staff told us friends and family test feedback was shared with teams. Suggestion boxes were available in outpatients and diagnostic imaging departments and feedback from these was provided to the team.
- Physiotherapy outpatients carried out friends and family test and recent results showed that 99% of respondents would recommend the service.
- Outpatients were part of the trust 'you said, we did' programme where patients and visitors could highlight any comments and the services were able to act upon these.

Staff engagement

- Managers told us they were planning to implement a staff wellbeing group across the access, booking and choice service
- There was a monthly audit session where teams tried to have team meetings and training such as mandatory training could be completed, however team meetings were not consistently held each month. Ophthalmology outpatients had a monthly team meeting.
- Staff bulletins were provided to staff from the organisation. Services such as dermatology operated a staff awards.
- The outpatient 2016 staff survey showed the positives and areas for improvement in outpatients. For example a highlighted positive was staff having good access to all of the materials and supplies to carry out my role and

confidence to approach senior management team. Areas for improvement included training and development needs not discussed in appraisal and not had any training/ development in last 12 months. The survey poster development by outpatients highlighted that managers intended to set up a staff health and wellbeing group. The poster also highlighted that volunteers from each team would be involved to represent their team.

- An access, booking and choice staff bulletin from May 2017 showed the suggestions made and what the service did regarding the suggestion.

Diagnostic imaging:

- Department managers told us that there were formal team meetings as well as informal meetings and team leaders walked around departments every day to speak to staff.
- A daily staff huddle was carried out in the diagnostic imaging departments. This allowed staff to discuss any issues related to their work and plans for the day ahead or issues identified from the previous day. Staff could discuss concerns they may have or receive and share important information. Staff told us these were good for regular updates about the service and to receive information from other parts of the trust.
- Policies and procedures were available to staff via the trust intranet and lead radiographers supported staff to access information.
- Departmental staff liaised with teams and specialists from other hospitals within the trust and neighbouring trusts as well as through national groups and panels to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.
- The department funded an annual whole radiology away day to support staff engagement in general, encourage whole team business planning and supported continual professional development of individuals and teams.
- Morale boards had been implemented on each site to enable staff to share issues, encourage staff support, and implement changes.

Innovation, improvement and sustainability

- The access, booking and choice division had an improvement action plan. This had 14 actions included, six of these were complete, and eight of these were not complete at the time of the inspection. One action had not been completed in the target date; all other actions were within the target date.
- We spoke with managers in different areas of outpatients and diagnostic imaging and some had attended an improvement workshop at the organisation.

Diagnostic imaging:

- Staff were proactive and innovative in terms of presenting new ideas for practice locally and nationally.
- Radiographer discharge had been developed for patients with normal x-rays under an emergency department prescribed development plan. Staff told us this reduced patient journey times and therefore improved patient satisfaction.
- Staff had developed direct access pathways within interventional radiology for palliative patients to avoid unnecessary admissions.

Outstanding practice and areas for improvement

Outstanding practice

•Emergency Surgical Clinics were established in January 2017, which provided an opportunity for admission avoidance for the less acute patient that requires a surgical review. These patients were previously admitted and waited as an inpatient for this service. The service also provided fast track access to diagnostics for the patient e.g. ultra sound and CT scans as well as providing access to theatre lists, which provides 20 hours of expedited operating capacity.

•The Plastic Surgery Assessment Unit was developed November 2016. This was designed to improve the patient experience across the division and ensure capacity was maintained for the assessment of ambulatory patients that required a plastic surgery assessment by assessing patients direct from the emergency department.

•There were fast tract clinics for women with post-menopausal bleeding which included same day access to diagnostic outpatient procedures.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that mandatory training levels are meeting the trust standard.
- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.

Action the hospital SHOULD take to improve

- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.
- Ensure that all staff have annual appraisals.
- Continue to focus on achieving A&E standards and ensure that improved performance against standard is maintained.
- Ensure that records are completed fully and that records are stored securely.
- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians.
- Continue to address issues of non-compliance with referral to treatment indicators and the backlog of patients waiting for appointments.
- Ensure work to improve the completion of consent forms in line with trust expectations.
- Review the risk registers and remove or archive any risks that no longer apply.
- Increase local audit activity to encourage continuous improvement.
- Ensure it continues to address capacity and demand across all outpatient services.
- Consider ways of ensuring team meetings in main outpatients are regular and consistent.
- Consider ways of ensuring environmental compliance issues with carpets in departments.
- Improve the assessment and recording of patient pain scores.
- Ensure there are appropriately qualified or experienced children's nurses in ED.
- Undertake clinical audit in ED to ensure that national and local standards of care are being met.
- Improve the reliability of the blood diagnostic service.
- Ensure that robust recruitment and retention policies continue, to improve staff and skill shortages; with particular emphasis on theatre recruitment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of patients.** • Pinderfields resuscitation unit staffing did not meet national 1:1 guidance • Maternity staffing levels were below national guidance. • General staffing levels in the ED department for nursing and medical staff was low with a high level of agency/ bank/locum use. • Best tool carried out and staffing levels do not match the BEST tool.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1)(c) **Care and treatment must be provided in a safe way for service users. The things which a registered person must do to comply with that paragraph include—** **(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.** • Staff continued to fail to meet the trust mandatory training standard of 95% • Lack of training across the departments in triage/IAT. This means that potentially less experienced staff are triaging/IAT patients. This occurred in both adults and children.

This section is primarily information for the provider

Requirement notices

- Staff attendance at other statutory training such as life support skills were not meeting the trust standard. This was a compliance action at our last inspection.
- The emergency department had no currently qualified APLS nurses or registered children's nurses.