The Mid Yorkshire Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

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

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

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

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

Summary of findings

departments at Pinderfields and Dewsbury District Hospital and in the mortuary at Dewsbury and District Hospital that were not clean and infection control procedures had not been followed.

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

We saw areas of good practice including:

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

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

Importantly, the trust must:

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

Summary of findings

- The trust must ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users.
- The trust must ensure there are improvements in the number of fractured neck of femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours.
- The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.
- The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

In addition the trust should:

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- The trust should ensure staff are involved and informed of service changes and re-design.
- The trust should take actions to address the historical management–clinician divides that had not been resolved amongst certain surgical specialities.
- The trust should ensure in community inpatient services there is a referral criteria for the service and in-reach assessments are carried out consistently to improve the admission and referral process.
- The trust should ensure toilet facilities in community inpatient services are designated same sex, in order to comply with the government's requirement of Dignity in Care.
- The trust should ensure care and treatment of service users is only provided with the consent of the relevant person.
- The trust should ensure patients receive person-centred care and are treated with dignity and respect.
- The trust should ensure the equipment and premises are suitable for the purpose for which they are being used and are appropriately maintained.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to The Mid Yorkshire Hospitals NHS Trust

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

The health of people in Wakefield is generally worse than the England average. Deprivation is higher than average and about 20.6% (12,500) children live in poverty. The health of people in Kirklees is varied compared with the England average. Deprivation is higher than average and about 18.6% (15,900) children live in poverty. Life expectancy for both men and women is lower than the England average. The population had a similar age group breakdown to the England average. In Wakefield there was a much lower proportion of black, asian and minority ethnic (BAME) residents with 4.8% BAME residents compared to an England average of 14.6%. In the Kirklees area there was 20.8% BAME residents which was a higher proportion than the England average.

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

Our inspection team

Our inspection team was led by:

Chair: Dr Bill Cunliffe

Head of Delivery: Adam Brown, Care Quality Commission

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

How we carried out this inspection

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

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

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

Summary of findings

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

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

What people who use the trust's services say

Data from the friends and family test (Dec 2013 – Nov 2014) showed over 94% of patients would recommend the trust to their friends and family.

The 2014 adult inpatient survey looked at the experiences of over 59,000 people who were admitted to an NHS hospital in 2014. Between September 2014 and January 2015, a questionnaire was sent to 850 recent inpatients at each trust. Responses were received from 363 patients at The Mid Yorkshire Hospitals NHS Trust. The results showed the trust was performing about the same as most other trusts that took part in the survey for all of the categories reviewed and for patient's overall experience.

The 2014 children and young people's survey looked at the experiences of nearly 19,000 people who received inpatient or day case care during July, August and September 2014. Responses were received from 177 patients at The Mid Yorkshire Hospitals NHS Trust. The results showed the trust was performing about the same or better than most other trusts that took part in the survey for all of the categories reviewed and the trust performed better for patient's overall experience.

Facts and data about this trust

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

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

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

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

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Throughout the inspections we found nurse staffing levels on wards continued to be a problem in the trust. There was significant shortages of nurses on the medical wards, community inpatient units and in the specialist palliative care team. There was also shortage of medical staff within end of life services. We found that most areas we visited were clean however there were areas in accident and emergency departments and in the mortuary at Dewsbury District Hospital that were not clean. We saw that infection control procedures were not always being followed. Following the CQC inspection in July 2014 a warning notice was issued to the trust for medicine management which included safe storage and administration of medications. We saw in most services there had been improvements in the administration and storage of medicines however in the intensive care unit in Dewsbury District hospital there were concerns regarding the temperature of the medicines room and on Gate 41 at Pinderfields fridge temperatures had consistently exceeded the maximum temperature. There were robust reporting arrangements of incidents across the organisation through the electronic reporting system, with staff articulating how incidents were disseminated and lessons learnt. There was an open culture to reporting incidents across the organisation with staff saying they were encouraged to report incidents. The trust has reported one never event in relation to medicine administration. For further detail please refer to the individual location reports for the trust. **Duty of Candour** • The duty of candour regulation ensures that providers are open and transparent with people who use services in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. • The Trust had a standard operating procedure (SOP) that detailed how the Trust would ensure they met the requirements	**Inadequate** 

of 'duty of candour'. The SOP included a checklist and flow chart to guide staff and a 'feedback letter' template. Duty of candour had also been incorporated into the trust's "being open" policy.

- Duty of Candour fields had been added to the Datix reporting system to enable the Trust to:
  - Capture that verbal notification has been given and to whom
  - Whether a written notification had been requested
  - Attached copies of written correspondence for when it was requested by the patient.
- Staff we spoke with were aware of their responsibilities under the duty of candour requirements. They also told us of the complaints process included duty of candour and feedback mechanisms to patients.
- We reviewed a number of serious incident root cause analyses and complaint responses and saw examples of where the trust had informed the patient or relative of a harmful incident.

Safeguarding

- The chief nurse was the executive lead and there was a non-executive lead on the board for safeguarding.
- There was a team of safeguarding staff within the trust whose role it was to ensure the trust's safeguarding practices met current regulations and to provide support and training to staff. These included a head of safeguarding and named nurses for safeguarding adults, safeguarding children and midwifery**.** The trust also had specialist practitioners for domestic abuse early intervention and a mental capacity act specialist advisor.
- An annual report on safeguarding was presented to the board in September 2014 and provided a summary of all safeguarding activity; it highlighted the areas that had been a focus of development over the annual report period that had been over seen by the trust safeguarding group.
- The safeguarding team had their own risk register which identified safeguarding concerns across the trust for example this included children who did not attend their appointments and non-compliance with safeguarding supervision.
- The trust had achieved overall compliance with safeguarding training with rates of:
  - Safeguarding Adults Level 1 100%
  - Safeguarding Adults Level 2 84%
  - Safeguarding Children Level 1 100%
  - Safeguarding Children Level 2 84%
  - Safeguarding Children Level 3 92%

Summary of findings

- Staff were aware of safeguarding processes and could explain what was meant by abuse and neglect. This process was supported by staff training. Staff were able to discuss issues around sexual exploitation and female genital mutilation. These issues were contained within the level 3 safeguarding programme.
- The trust had policies and procedures in place which included a safeguarding adult's policy, safeguarding children's policy, restraint of adult's policy and a female genital mutilation (FGM) policy.

Incidents

- There was a policy in place for the reporting and investigation of incidents: incidents were reported electronically using an online reporting system (datix).
- There had been one never event which related to a medication incident which involved methotrexate in September 2014. We saw an investigation had been completed and an action plan developed.
- There was evidence of trust wide learning for example minutes of surgery ward meetings showed learning from the methotrexate incident had been shared to ensure the drug was managed as a controlled drug, prescribed separately and that pharmacy was informed of patients who were receiving the drug**.**
- There had been 258 Serious incidents reported between May 2014 and April 2015, the most common type being pressure ulcers (206) at grade three. The trust had shown a fluctuating rate of pressure ulcers over time, it's highest in Oct 2014.
- Each month papers were presented to the board on category three and four pressure ulcer serious incidents and the prevalence across the trust.
- Between December 2013 to December 2014 the number of falls with harm had reduced over this time period (218 were recorded in total).
- The trust produced newsletter called "risky business" the aim of newsletter was to share information and learning across the organisation following the occurrence of incidents, never events and serious incidents (SI's) to ensure patients were protected from harm. Examples of these included information on pressure ulcers and falls.
- At the March 2015 board meeting a paper had been presented paper to escalate to the board that there has been a 6% increase in the proportion of reported harmful incidents in January 2015 compared to December 2014.

- Information showed the main shift change was due to an increase in 'low harm' incidents with a decrease in reporting of 'no harm/near miss' incidents, particularly in the division of medicine and care closer to home. The reporting of low harm' category one and two pressure ulcers had seen the most significant rise.

Infection control

Accident and Emergency

- One of the must do's in the CQC inspection report from 2014 report was to ensure that all equipment in the accident and emergency departments (ED) was appropriately cleaned, labelled and stored in the correct environment. At this inspection we found there were continued concerned regarding the infection control practices within ED.
- At this inspection we found "I am clean" assurance stickers were in use however their use was not consistent and equipment was found not to be clean despite having a label on indicating it was clean.
- At Pinderfields ED an internal infection prevention and control (IPC) audit in May 2015 a score for cleanliness of patient equipment was noted as 80%.
- At Dewsbury District hospital in the ED we were concerned about the cleanliness within the department we raised our concerns with senior nursing staff and domestic supervisors. The floor in the children's ED waiting area looked dirty and debris was found, old stickers were stuck to the floor. The walls in the children's ED cubicles were also seen to be dirty with staining and markings present.
- During the inspection two patients complained to the inspection team that the main toilet in the department was dirty, we inspected the toilet and found it to be dirty and stained, the soap dispenser also wasn't working. We highlighted this to a member of staff and when we inspected later it was found to be clean and the soap dispenser was working.
- In April 2015 a specific action plan for IPC was reviewed and equipment was found to be not labelled and some equipment was found damaged and dirty.

End of Life services

- At the CQC July 2014 inspection infection control practices had been identified as an area for improvement. At this inspection

we found continuing concerns regarding poor infection control practice (IPC) at the mortuary in Dewsbury District hospital and the trust had failed to sustain changes and address the infection control issues.

- We found that staff were not always protected from the risk of infection. We observed staff to be wearing their own clothes, which were partially protected by standard aprons. Their footwear and lower garments were not protected from spillages.
- We saw the doors of the fridges were scratched and dented which would not allow for effective cleaning.
- We found there was no evidence the trolleys were cleaned on a daily basis at a weekend or on bank holidays. The trusts end of life care policy stated 'the porter must always decontaminate the trolley after each use before returning the trolley to the hospital and decontaminate his/her hands.' The mortuary trolley was not routinely cleaned after each use; we were told it was cleaned on a daily basis Monday to Friday, as was the one concealment trolley.
- We observed leakage from a deceased person inside a fridge who was not in a sealed bag. There were two other deceased patients stored below them.

Medicine management

- Following the CQC inspection in July 2014 a warning notice was issued to the trust for medicine management which included safe storage and administration of medications.
- At this inspection we found the trust monitored services the pharmacy provided to wards on the pharmacy performance dashboard. This included a range of measures which showed information on medication incidents, never events, times taken to prepare take home medications and medicine reconciliation.
- We saw information on medicine reconciliation which showed improvements from August 2014 where the rate was 59% to March 2015 where the rate was 79% on the medical admissions unit. The director of pharmacy told us further work was being undertaken to improve rates across all inpatient wards.
- Staff told us where concerns or errors had occurred staff undertook further medicines management training and this had to be completed before they were allowed to take part in further medication rounds. This was confirmed during interviews with the director of pharmacy.
- Across the different services, we found that oxygen was not always prescribed.

- On Gate 41 at Pinderfields we found medication fridge temperatures had been recorded daily in June. On 23 out of 24 days the temperature had exceeded 8 degrees centigrade. There was no evidence to indicate that any action had been taken in relation to this.
- On other wards we visited we found records showed that fridge temperatures had been monitored and recorded.
- On the intensive care unit at Dewsbury we found medications were stored in a designated room, the door to this room was 'propped' open when we arrived on the unit. The room felt very warm and the temperature was seen to be 27.1°c. The recommended room temperature for the storage of medicines is between 15°c and 25°c (Guidelines for the storage of essential medicines – World Health Organisation).
- The director of pharmacy told us they were rolling out electronic monitoring of fridges and medication rooms and these were monitored by the pharmacy department. They said this was due for completion in September 2015.

Staffing

The National Quality Board (NQB) published staffing guidance 'How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability' in November 2013. Within this document the NQB detailed ten expectations trust boards were expected to follow.

Expectation 1**:** Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Our findings showed:

- Reports were presented to the board on safe nurse and midwifery staffing with a monthly update in relation to acute nursing for inpatient areas within the trust. The trust report detailed a retrospective analysis of staffing levels day by day and for each ward at each site.
- The chief nurse told us staffing levels throughout the trust had been reviewed 18 months ago and recently the trust had reviewed these. The chief nurse said on adult inpatient wards the nurse to patient ratios were generally based on one nurse to eight patients.
- A six month staffing review paper was presented to the trust board in July 2015. The paper detailed the inpatient ward area

establishments within the trust and reported the trust was one nurse to eight patients compliant during the day. On review of nurse staffing information we found nurse staffing levels did not consistently meet the one nurse to eight patient ratio's.
- High levels of registered nurse and care staff vacancies were identified on the corporate risk register.
- On review of the monthly nursing and midwifery staffing reports we found the reports were very detailed with most being over 100 pages long as a consequence it was difficult to easily identify the most urgent risks and concerns due to the length of the reports.

Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. Our findings showed:

- The trust had developed safe nurse staffing escalation for in-patient areas policy (April 2015) the aim of the policy was to provide effective support to staff who had responsibility for safe nurse staff decision making on a shift by shift basis. During our announced inspection we saw examples of how the trust used the policy to support decision making around safer nurse staffing. Senior nurses and the chief nurse reported they felt more assured that they were fully aware of the issues with nurse staffing each day.
- At the unannounced inspection in August 2015 we had significant concerns regarding nurse staffing levels and found polices and procedures were not always followed and escalation of staffing risks did not always happen.
- Following the unannounced inspection we met with senior nursing staff within the trust who acknowledged at the time of the unannounced inspection in August 2015 the safe nurse staffing escalation policy had not been consistently used to support decisions about safe nurse staffing particularly the completion of the organisational risk assessments. As a result of our inspection and feedback the trust reported they had strengthened the process and these were reviewed by one of the deputy chief nurses each day.
- We saw information within the organisational risk assessment which highlighted the increased support to the wards by matrons and patient service managers (PSM's) for example we saw on 11 September 2015 "Matrons (name x 2) have supported Gate 42 this morning and are returning to Gate 41 this afternoon." One of the deputy chief nurses and matrons told us the support consisted of "hands-on" patient care to support patients and staff on the wards.

Summary of findings

Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. Our findings showed:

- The trust was using the safecare tool to review patient acuity and dependency on each ward. In March 2015 the trust commissioned the Merseyside internal audit agency to review the safecare process: the method by which patients' acuity/ dependency was assessed and entered into the safecare application within health roster and providing visibility of staffing levels across wards and departments.
- The report found there was a need for the trust to improve the ward nursing teams understanding of safecare and its impact in decision making in relation to nurse allocations. To support the improvement work a safe care improvement action plan was developed to deliver actions over the next five months.
- We saw detailed in the six month staffing review paper July 2015 recommendations had been made following deployment of the Safer Nursing Care Tool (SNCT) in May 2015 and the subsequent analysis triangulated against relevant nursing quality metrics data and professional judgement.

Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. Our findings showed:

- Senior nurses and staff on the wards told us they had mechanisms in place to capture staffing shortfalls. This was achieved through the trust's datix incident reporting system or by raising 'red flags' on the safer nursing care tool.
- However staff told us when they had raised staffing concerns they were not always clear on the actions the trust had taken to mitigate the risks in relation to nurse staffing.
- We saw information in the governance, patient harm and patient experience report for the division of medicine which showed there had been 469 reported incidents related to staffing between January to March 2015. In the reports (for June and July 2015) we found in April 2015 there had been 129 incidents and 181 incidents in May 2015 related to staffing levels.

Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. Our findings showed:

- We found there was information which indicated band 6 staff, ward managers and senior nursing staff were involved in

collecting and analysing information on nurse staffing levels. It was less clear within the trust that a multi-professional approach had been used to set nursing, midwifery and care staffing establishments.

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. Our findings showed:

- There was an "uplift" within staffing establishments to allow for study leave, annual leave and unplanned leave. However some wards particularly in the division of medicine had significant registered nurse vacancies which made it difficult to maintain planned or minimum staffing levels.
- Information within the six month staffing review paper July 2015 indicated that ward establishments had been set to include the provision of a supervisory ward manager. Most of the ward managers we spoke with told us and from reviewing staff off-duty information which indicated ward managers were included in the numbers daily to support the ward to meet planned or minimum staffing levels.

Expectation 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. Our findings showed:

- Reports were presented to the board on Safe Nurse and Midwifery Staffing with a monthly update in relation to acute nursing in inpatient areas within the trust. The trust report detailed a retrospective analysis of staffing levels day by day and for each ward at each site.
- There was information within the monthly trust reports to triangulate staffing levels with pressure ulcers, complaints, incidents and 'red flags.' This was broken down into information for each ward at each site.
- A six month staffing review paper was presented to the trust board in July 2015.

Expectation 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. Our findings showed:

- Information was visible on nurse staffing ratio's on display boards on the entrance to each ward. However during our inspections we saw information was not always updated to display nurse staffing information for each day.

- The monthly nurse staffing report had not been published on the trust's website under the page safe nursing and midwifery staffing levels since April 2015. There is national guidance to publish monthly staffing data on the trust's website each month.
- We did find information in the board papers on safe staffing levels these were published onto the trusts website but this could be difficult for members of the public to find as they were contained within the board papers and not on safe nursing and midwifery staffing webpage.

Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements. Our findings showed:

- The trust had been undertaking international recruitment to fill vacancies within the organisation the chief nurse told us there had been three rounds of international recruitment in addition to local recruitment. In February 2015, 89 nurses were offered posts at the Trust, arriving in cohorts throughout the year. In June 2015 this figure had reduced to 78.,a further 10 nurses were offered positions in July 2015.
- The chief nurse told us following our unannounced inspection in August 2015 there were 111 WTE registered nurse vacancies across the trust. Subsequeltly one of the deputy chief nurses told us the board had made the decision to proactively recruit to vacancies rather than wait for staff to leave this was to achieve safe staffing levels on wards.
- The trust was one of four pilot sites for the department of health to test the developing temporary staffing toolkit. The diagnostic tool identified the opportunity for the trust to review its current management of temporary nurse staffing, and the need to scope other staffing supply options.
- The trust was involved with the Lord Carter project. In February 2015 the trust completed and submitted a detailed staffing template, which included bed numbers, planned and actual registered nurse and health care assistant hours, and hours filled by bank and agency nurses. The Carter review of the nursing eRoster data highlighted that many of the wards were not managing to achieve the nursing hours required to sustain the budgeted establishments.

Expectation 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. Our findings showed:

- Following the unannounced inspection a risk summit was held to look at what actions the trust needed to take to ensure safe staffing levels were achieved and what support was needed from the wider health community to support the trust with this. This meeting was chaired by NHS England. A health economy action plan was developed with commissioners to support the trust to make the improvements they needed to ensure patients were protected from harm.
- The trust at the time of the unannounced inspection had 24 extra capacity beds open and this had impacted on staffing levels on other wards. The chief executive confirmed on 7 September 2015 that in agreement with their commissioners all the extra capacity beds had closed and they would not admit to them in future unless they were part of a funded winter strategy and any beds used were safely staffed in accordance with the trust'snursing safety standards and escalation policies.

Medical Care Staffing

- Throughout the inspections we found nurse staffing levels on wards continued to be a problem in the trust. We reviewed information the Safe Nurse and Midwifery Staffing: public board paper for May and July 2015. We saw within the Division of Medicine the vacancy position in October 2014 was 37.60 WTE and had steadily increased month on month to 16% or 74.95 WTE in April 2015. In July 2015 the vacancy rate across the division was 81.52 wte (18.3%) this had increased from the April 2015 position.
- During our unannounced focussed inspection on 25 August 2015 we attended a bed meeting at 12.30 in the hospital and found of the 17 wards at Pinderfields there were six wards below minimum staffing and10 wards on minimum staffing levels. There was one ward which was staffed to safe staffing levels that day.
- At the inspection on 25 August 2015 we had serious concerns regarding the registered nurse staffing levels on Gates 20, 41, 42 and 43 which had impacted on the care patients received. For example we found one patient who had been identified as requiring one to one care had not received one to one care and had fallen and sustained an injury. Staff had identified this incident as avoidable harm. When we spoke to staff they were not clear if one to one care had been arranged for the following night.
- We also had concerns regarding the fluid balance monitoring and nutritional assessments of patients on the ward; we found that not all charts were always fully completed.

Summary of findings

- Following the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information which detailed the immediate, short-term and longer term actions they were going to take to make the improvements that were needed.
- The information to CQC highlighted what immediate actions they had taken to support nurse staffing on the wards. These included utilising staff within corporate nursing teams to support the wards each day with discharge planning and supporting patients with their nutritional needs. We saw the trust had developed rota's to identify which staff would support which ward.
- The trust had also booked an additional 12 safety guardians or health care assistants to support the four wards.
- We saw information within the organisational risk assessment which highlighted the increased support to the wards by matrons and patient service managers (PSM's) for example we saw on 11 September 2015 "Matrons (name x 2) have supported Gate 42 this morning and are returning to Gate 41 this afternoon." One of the deputy chief nurses and matrons told us the support consisted of "hands-on" patient care.
- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward. Staff we spoke with confirmed the additional support they had been receiving since our unannounced inspection on 25 August 2015.

Community Inpatients Staffing

- The previous CQC inspection in July 2014 identified that the trust must take action to improve staffing levels and ensure staffing levels were safe to meet the needs of patients. At this visit we found the staffing levels at the service had deteriorated since the last inspection in July 2014.
- Senior staff were unable to tell us what the current staff establishment for the service was. We were told there was to be a full service review, which would include identifying the staffing establishment required. However, we were not shown any evidence to confirm this.
- We found the service was still not using an appropriate dependency or acuity tool or assessing the dependency levels of patients. When we asked senior nursing staff about this, we were told, "No work has been done to look at the dependency of patients in the unit or at skill mix."

- The service used a high proportion of non-permanent staff to fill the gaps in the rotas. These included agency staff and staff from other areas of the trust. Staff rotas showed that 96% of shifts in a four week period (18 May 2015 to 28 June 2015), across both sites, used at least one non-permanent member of staff (from agency, bank or community). Two shifts were identified in this period where only one RN was on duty. This meant the nurse to patient ratio on those shifts would be one to 24 (at Monument House) or one to 26 (at Queen Elizabeth House).

End of Life services Staffing

- The risk register indicated there were five whole time equivalent (WTE) vacancies within the SPCT. We were told several efforts had been made to recruit but these had been unsuccessful. The person specification had been changed in February 2015 to allow increased shortlisting to take place.
- The specialist palliative care team (SPCT) told us they were established for 9.8 WTE nurses, however, when we inspected the service there were three clinical nurse specialist (CNS) staff members, one was a band 7 and two others were band 6. One of those was in a seconded role as end of life care facilitator. This had been made into a permanent role and meant further recruitment was needed.
- We found that medical staff levels and skill mix were unsatisfactory. The clinical director (one of the consultants) told us there had previously been five consultants, and three were leaving or had left already. The other consultant was due to take up a post at a hospice, which would leave one consultant, who was contracted to provide four hours clinical service a week. The Trust had advertised for permanent medical staff but had been unsuccessful in recruitment.
- Information provided by the trust before our inspection stated there were 2.6 WTE consultants, when we inspected we were told it was less than this, the second consultant was based at a hospice and was available for two clinical sessions a week for both Dewsbury and Pinderfields. The specialist registrar was soon to go on extended leave. There was some hospital cover provided by GP's on a temporary basis.
- We were shown minutes from the trusts Palliative Care Joint Operational Meeting which indicated a replacement consultant post was not expected to be filled before January 2016 due to recruitment difficulties.

Summary of findings

Are services at this trust effective?

Requires improvement 

Patients nutritional and hydration needs were not always assessed using the Malnutrition Universal Screening Tool (MUST). There was a 'red tray' system in use in the trust to identify those patients who required assistance at mealtimes. At both unannounced inspections we reviewed fluid balance monitoring and nutritional assessments and found that not all charts were fully completed.

Following the CQC inspection in July 2014 a warning notice was issued to the trust in relation to safeguarding service users from abuse where we found training on the mental capacity act (MCA) and deprivation of liberty safeguard (DoLS) training was not part of mandatory training provision for nursing or medical staff throughout the trust. We found training percentages were low at 5% and some staff had little or no understanding of MCA or DoLS. At this inspection staff spoke to us about their knowledge and experience of the mental capacity act (MCA) and deprivation of liberty (DoLS), staff were aware of procedures for gaining consent and the need for referrals where required.

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. There was an annual audit programme in place across the core services, with audits undertaken being monitored and actions taken to improve clinical practice.

For further detail please refer to the individual location reports for the trust.

Evidence based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust intranet.
- There was an annual audit programme in place across the core services, with audits undertaken being monitored and actions taken to improve clinical practice.
- At the last inspection there were concerns raised by some doctors about compliance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD); that there was not a dedicated general surgery list. We were informed at the time by the trust that funding was being agreed to provide a general surgery only CEPOD list. The minutes of the general surgery business meeting on 15 April 2015 stated that the current CEPOD lists were being looked at with the proposal that a Friday CEPOD list was to commence by end of April 2015, however this was not possible at this time as a business case was needed. At the time of our inspection it therefore remained unclear what action had been taken to resolve the issue.

- We discussed in detail the process for dealing with emergency cases to ensure compliance with NCEPOD classification with the senior management team. The data they presented showed that there had been a modest increase of post 8pm operations (approximately 5-10%) over the last 12 months from June 2014. Within the following few months, the Dewsbury surgeons would be operating on their emergency patients at Wakefield and if the national emergency laparotomy audit data was an accurate reflection of the total comparative workloads, this would mean an extra 30% of patients would need to be accommodated on the Pinderfields site. This clearly would have a major impact on the out of hour's service and it was not clear how the division would accomplish this without a dedicated general surgery operating theatre.

Patient outcomes

- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution, in addition adjustments are made for other factors including deprivation, palliative care and case mix. The HSMR reported in the quality account in June 2015 was 91.91. The Summary Hospital-level Mortality Indicator (SHMI) was also reported at 87.60 in the quality account.
- There were two current CQC mortality outliers relevant to the trust which related to cerebrovascular conditions and dermatological conditions.
- The CQC 2014 national survey of patient experience in the emergency department indicated that the trust scored the same compared to other trusts for all questions such as the arrival at the department, tests undertaken, hospital environment and facilities and leaving the department
- In the CQC 2015 national inpatient survey the trust scored the same compared to other trusts for all questions which included overall experience, care and experience and operations and procedures.
- Participation in the College of Emergency Medicine (CEM) Audits 2014-15 was noted to be 100%, however mixed results were noted and little evidence was available of departmental learning or change from the recommendations or findings. The CEM recommends that unplanned re-attendance rates within seven days for EDs should be between 1% and 5% of total attendances. Pinderfields hospital was higher than the England average on re-attendance rates to ED in July 2014 to May 2015 with a re-attendance rate of 9%.
- The trust contributed to all national surgical audits for which it was eligible. National audit data for bowel and lung cancer

showed outcomes were within expected ranges. The trust performed better than the England average; for example, being seen by a clinical nurse specialist, reporting of the CT scan and discussion of treatment by a multi-disciplinary team.

- The trust participated in the national hip fracture audit. Findings from the 2014 report showed the trust was better than the expected England average in areas such as patients receiving bone protection medication, pre-operative assessment by a geriatrician and falls assessment. The trust was worse than the England average for patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours. For example, 73% of fractured necks of femur were seen within 48 hours against the national target of 87%. The senior team in surgical services were aware that further work was required to improve in this area, and were looking at processes for organising trauma cases, improving communication between orthopaedics and the ortho-geriatrician and ring fencing beds.
- Within the diagnostics and radiology service there was a designated radiologist for research. We found they produced an annual report on audit and research activities within the department. We found the department had an annual audit plan with estimated start and end dates. For example we saw there was an audit planned to start in September 2015 of Magnetic resonance imaging (MRI) scans in Transient ischaemic attacks (TIA's) and was due to end in March 2016. This was to audit against NICE guidance.
- The trust participated in a national audit of bereaved relatives from January to March 2014, 29 relatives took part. The comments from the survey indicated many patients and families received good care and felt well supported, although the audit highlighted that these comments had not been consistent and other families reported great difficulties. The report stated the trust was aiming to achieve 100% in future audits.

Nutrition and Hydration

- Throughout the inspection on the medical wards we visited we found malnutrition universal screening tool (MUST) was not always completed fully. We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking.

Summary of findings

- When we visited the wards for the unannounced focussed inspection on 25 August 2015 we reviewed fluid balance monitoring and nutritional assessments. We found that not all charts were always completed fully.
- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We reviewed 14 food and fluid charts and found patients had them for each day however we found these were not always fully completed.
- In the 2014 survey of emergency departments, the trust performed about the same as other trusts for the question, "Were you able to get suitable food or drinks when you were in the A&E department."

Multidisciplinary working

- Staff across the hospital reported good working relationships within the multidisciplinary teams (MDTs).
- Since the last inspection in surgical services there had been improvements in the backlog of un-typed clinical letters to ensure clinical information was available for example to a patient's GP. At the end of March 2015 there were 80 letters requiring dictation which were over the five day target compared to 196 in February 2015. The number of days waiting for the oldest dictation was nine days in May 2015.
- There remained delays in sending discharge letters to GP's within 24 hours. Performance data for April to May 2015 showed 25% of letters had been sent, which was below the target of 90%.
- Staff in the ED department spoke positively about the relationship with the newly formed mental health liaison team; this new service provided mental health advice and guidance 24 hours, seven days a week. Staff felt this had improved services for mental health patients.
- We saw evidence of good internal and external MDT working in patient records, for example collective working between medical staff, nurses, community teams and hospice staff.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Following the CQC inspection in July 2014 a warning notice was issued to the trust in relation to safeguarding service users from abuse where we found training on the mental capacity act (MCA) and deprivation of liberty safeguard (DoLS) training was

not part of mandatory training provision for nursing or medical staff throughout the trust. We found training percentages were low at 5% and some staff had little or no understanding of MCA or DoLS.

- At this inspection staff spoke to us about their knowledge and experience of the mental capacity act (MCA) and deprivation of liberty (DoLS), staff were aware of procedures for gaining consent and the need for referrals where required.
- The trust had developed a policy for the mental capacity act (2005) policy and guidance in October 2014.
- The trust had appointed a mental capacity act specialist advisor and had members on the local safeguarding adult board sub groups for MCA and DoLS. The trust's senior management team acknowledged the improvements made but that they still had work to do to improve knowledge and practice in relation to MCA and DoLS
- We found training participation rates had improved across services for level 1, 2 and 3 MCA and DoL's training.
- The trust provided information for the division of medicine which showed levels of training for MCA/ DoLS. We saw 83% of staff had completed level 1, 44% had completed level 2 and 59% had completed level 3 training. In surgery compliance rates were level 1 93%, level 2 50% and level 3 56%.
- In the community inpatient service we found the service was not meeting the requirements of the DoLS. The doors at Queen Elizabeth House were kept locked and the gates to the garden were locked. When we asked staff about this they said some patients could go out but they would let them out, they would not give them the keypad code. This meant all patients resident at the unit had their movements restricted and they were being deprived of their liberty without an agreement being in place.
- There was a do not attempt cardio-pulmonary resuscitation (DNACPR) policy in place; the policy included instructions on communication decisions when a patient lacked capacity. . A trust wide audit report in October 2014 indicated there had been a marginal improvement in communication of DNACPR orders with regards to the numbers of wards correctly identifying patients with a DNACPR form; this had risen from 78% in 2013 to 79% in 2014.
- The 2014 audit indicated only 50% of patients who lacked capacity had received either a capacity assessment or had dementia screening; however this was an improvement from 2013 when only 13% of those patients had received a capacity assessment.

Summary of findings

- Staff in the specialist palliative care team told us they had worked closely with the safeguarding team to include mental capacity issues into the end of life care plan. They felt this had supported some improvement.

Are services at this trust caring?

Good

Patients on the whole told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner. In the 2015 CQC inpatient survey, the trust scored about the same as other trusts for patients being involved as much as they wanted to be in decisions about their care and treatment and the same as other trusts for patients receiving enough emotional support from hospital staff.

However during our inspection we observed a small number of staff speaking to patients in an unkind or disrespectful manner. We raised this with managers at the time of inspection who took immediate action. Some of the patients and relatives we spoke with said the staff was busy and sometimes too busy to do things although they tried their best to support them.

For further detail please refer to the individual location reports for the trust.

Compassionate care

- In the Care Quality Commission (CQC) A&E survey 2014 and the inpatient survey 2015 the trust performed about the same as other trusts for all the questions relating to care and treatment.
- As part of our inspections, we observed care on wards and observed staff speaking to patients and relatives on the telephone. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives who used services across the trust.
- Patients on the whole told us they were happy with the care they received and the attitude of staff. We observed staff engaging with patients in a caring and respectful manner.
- However during our inspection we visited Gate 43 for evening handover and observed a member of staff speaking to a patient in an unkind and disrespectful manner. We raised this with managers at the time of inspection who took immediate action. At the inspection on 22 September 2015 we also observed a member of security staff who had been called to assist nursing staff with a patient speaking to the patient in aggressive tone and manner.
- Some of the patients and relatives we spoke with said the staff was busy and sometimes too busy to do things although they

tried their best to support them. We spoke with three patients who told us they had had to wait unreasonable time to have call bells answered, or had been told that staff were too busy and would have to come back later.

- Patients at Queen Elizabeth House told us care offered was variable because the staff was "So inconsistent." For example, one patient told us some staff would offer biscuits with a drink and other staff would refuse. We observed this to be the case in the lounge at Queen Elizabeth House; when one of the inspection team asked staff about providing biscuits with drinks we found their attitude was unhelpful and abrupt.

Understanding and involvement of patients and those close to them

- In the 2015 CQC inpatient survey, the trust scored about the same as other trusts for patients being involved as much as they wanted to be in decisions about their care and treatment.
- In community inpatient services patients we spoke with told us had not been consulted or had any input about their expected dates of discharge (EDD), most were unaware of their EDD and had not been involved. One patient, who had been in QEH since May 2015 said, "I have no idea when I am going home." All of the patients and/or their relatives we asked told us patients had not been involved in their care planning.
- We found in the minutes of Gate 43 monthly staff meeting evidence that relatives of patients had been invited to share their experiences and concerns with staff at the meeting. Details of how the ward had responded to address some of these concerns were also documented in the minutes.
- We spoke to a patient and the relative of a patient with dementia. They told us that staff were caring but that they had not been involved in decisions. The carer told us that the care on the ward had been 'really good' and that buzzers were answered quickly. They said that they had been kept informed by the doctors and felt involved.
- Other relatives we spoke with told us that they would have liked more communication from staff about their relative.

Emotional support

- In the 2015 CQC inpatient survey, the trust scored about the same as other trusts for patients receiving enough emotional support from hospital staff.

Summary of findings

- Within surgical services patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general. There was information within the care plans to identify whether patients had emotional or mental health problems.
- However within community inpatient services patients, relatives and staff told us there were no activities offered or provided at the units. Some patients told us they amused themselves by reading, chatting or watching television, others told us it was "boring" and "a long day and even longer nights." When we asked senior nursing staff about activities, they told us therapy staff did exercise sessions in the lounge at Queen Elizabeth House and a therapy dog came in on Sunday afternoons.

Are services at this trust responsive?

Requires improvement

The trust was not meeting performance targets referral to treatment times within the trust did not meet the national standards for admitted, non-admitted and incomplete pathways. The trust had consistently not achieved the national standard for percentage of patients discharged, admitted or transferred within four hours of arrival to A&E.

We reviewed data from the trust relating to operations which started between 8pm to 8am. Best practice guidance indicates that out of hours operating may result in a poorer outcome for patients. The data showed that the mean number of emergency abdominal procedures performed at Pinderfields out of hours was 21.5 per month. There was no information as to whether or not the emergency lists were consultant led or what the outcome was or to the availability of critical care.

At our inspection in July 2014 we found there was a backlog in overdue outpatient appointments of 9,501. At this inspection the trust provided information on the outpatient backlog we saw in April 2015 the number was 3,716 and in June 2015 this number was down to three patients.

There was a full time learning disability liaison nurse and a dementia lead nurse and two dementia screening support workers to support staff to meet patient's individual needs.

For further detail please refer to the individual location reports for the trust.

Service planning and delivery to meet the needs of local people

Summary of findings

- The majority of the trust's services were commissioned by two clinical commissioning groups based on the needs of the local populations.
- Divisions were involved and responsible for developing business plans for their services.
- A new end of life care plan had been introduced at the hospital and focused on the 'five priorities of care'. These priorities were based on guidance from the leadership alliance for the care of dying people (LACDP).
- The trust had a policy 'Dealing with deaths of Muslim patients and procedures to be followed' which supported families of Islamic faith to obtain death certificates quickly. The policy referred to procedures to be followed if families wished to take the deceased patient out of England for burial.
- The division of surgery had worked with commissioners of service and clinical leaders in primary care to agree a new service model which included the separation of elective and non-elective surgery with the centralisation of emergency and complex surgery at Pinderfields.
- We found the trust had a policy for the management of the follow up waiting list (January 2015) the purpose of this policy was to minimise the clinical risk to patients who were waiting for a follow up appointment. The policy also outlined the process staff should follow to manage patients within the backlog of appointments.
- The next phase of the overall outpatient improvement plan was to look at services who managed their outpatient bookings outside of the call centre. Each service was to be reviewed separately so that decisions about outpatient bookings would be based specifically around the needs of that speciality.

Meeting people's individual needs

- The Trust had a permanent hospital liaison nurse for learning disabilities who was employed full time and they also had a part time strategic health facilitator for learning disabilities.
- The learning disability liaison nurse was aware of any patients admitted with a learning disability as they received an email each day which flagged all patients with learning disabilities on each ward at each site.
- The Trust (CAMS) central alert management system which supported identification of learning disability patients within the trust. This was based on patients having the vulnerable inpatient passports (VIP). We saw within services there were well established systems for flagging of patients as having a learning disability to adjust pathways of care and involve the specialist learning disability nurse.

- We saw in services the VIP was used and they held information about patients, which helped staff when patients sought medical help. The VIP could be used in Dewsbury District, Pinderfields and Pontefract Hospitals by anyone with a learning disability.
- Patients using colorectal and breast services were allocated a key worker, usually a clinical nurse specialist, who took a role in the coordination and continuity of the patient's care, including information, advice and access to other specialists when required.
- Within children's services at the inspection in July 2014 we found the service was not responsive to the needs of children and young people in that they did not have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes. At this inspection we found that the service had appointed a consultant, whose role was to lead on transition services. However, we found they had not been in post long enough to effect any changes.
- There was 24 hour access to Chaplaincy services for patients and relatives of all faiths.
- There were plans to create therapeutic side rooms for patients at the end of life on wards 42, 43 and 44. At the announced inspection work had been due to begin in July. We saw at the unannounced inspection in September 2015 these rooms had been created and were in use. There were 'comfort bags which contained toiletries and other items; staff gave the bags to family and carers to use if they were staying overnight.

Dementia

- The Trust had a dementia steering group in place which had been created in 2011 the dementia strategy had been reviewed and updated in March 2015.
- Within the trust there was a dementia lead nurse and two dementia screening support workers. These nurses accessed information all acute admissions and undertook dementia screening. Plans were in place to train all band 6 sisters and band 7 sisters to undertake dementia screening on their own wards.
- All patients admitted acutely aged 75 years and over were screened for dementia and delirium and this was part of the assessment for the dementia national CQUIN. The information was recorded on the trust vital pac system which meant when a patient was identified as having a diagnosis of dementia or delirium a red flag appeared next to the patients name on vitalpac which staff could then access.

- Within the trust the "forget me not" system was also used to support patients living with dementia
- Staff were working through the 'Person Centred Dementia Care in Acute Hospitals' work book which was facilitated by ward sisters.

Access and flow

- At our inspection in July 2014 we found there was a backlog in overdue outpatient appointments of 9,501. At this inspection the trust provided information on the outpatient backlog we saw in April 2015 the number was 3,716 and in June 2015 this number was down to three patients.
- Referral to treatment times did not meet the national standards for admitted, non-admitted and incomplete pathways.
- We reviewed information on the trust's performance for cancer waiting times. We found from October 2014 the trust performance for two week wait from urgent referral was between 97%-99% against a target of 93%. Between November 2014 and June 2015 the trust was generally meeting the 85% performance target for all cancers for the 62 days wait for first treatment from an urgent GP referral with the exception of February 2015 when it was 78.8%.
- The trust had consistently not achieved the national standard for percentage of patients discharged, admitted or transferred within four hours of arrival to A&E. The figures ranged from 83.2% to 88.6% between December 2014 and May 2015. Pinderfields had not met the 95% standard for the previous 12 months and Dewsbury District Hospital had not met the 95% target for the previous 6 months.
- The average bed occupancy in quarter three of 2014/15 for the trust was 86.4% and in quarter four it was 88.9%. This was above the 85% occupancy level where regular bed shortages and an increased number of health care associated infections can occur (National Audit Office).
- Information from NHS England (April2013 – November 2014) indicated that 35.5% (8,410) of delayed transfers of care were waiting for further NHS non-acute care compared to 20.5% nationally, with a further 26.6% (6,295) due to patient or family choice compared with 14% nationally.
- At our inspection in July 2014 medical staff told us there were often 20 to 30 medical patients (outliers) on the surgical wards. At this inspection we reviewed data which showed from 1 June to 11 July 2015 indicated that the number of medical outliers on any one day ranged from five to 35.

Summary of findings

- We reviewed information the trust provided between February 2015 to May 2015 that was taken as a "snapshot" once a week on a Thursday. The data showed that at Pinderfields there was between two and 11 patients admitted under a medical specialty based on a surgical ward.
- There continued to be concerns amongst some members of the consultant body regarding the lack of a National Confidential Enquiry into Patient Outcome and Death (NCEPOD) list for general surgery. We received mixed messages about the utilisation of theatres to accommodate emergency lists. The surgical management team stated that there was an emergency theatre 24 hours a day for cases undertaken in order of clinical priority using the CEPOD categorisation of acute trauma patients which was decided by surgeons and anaesthetists.
- The management team told us there had been no delays in patients needing immediate access (within an hour) or urgent access (within eight hours) from the theatre management data in quarter three and four of 2014/15. There were four delays for patients (0.2%) in the expedited category (waiting beyond 48 hours).
- We reviewed data from the trust relating to operations which started between 8pm to 8am. Best practice guidance indicates that out of hours operating may result in a poorer outcome for patients. The data showed that the mean number of emergency abdominal procedures performed at Pinderfields out of hours was 21.5 per month. There was no information as to whether or not the emergency lists were consultant led or what the outcome was or to the availability of critical care. A 50% sample (which excluded obstetric, gynaecological, orthopaedic and urological procedures) from 1 June 2014 to 29 January 2015 was checked. We found 93 general surgical, colorectal and abdominal emergency procedures were identified, 30 of those cases were commenced after midnight (32% of cases) and one case (on 26 and 27 January 2015) had waited 18 hours for a theatre slot.

Learning from complaints and concerns

- The Chief Nurse was the executive lead for the management of complaints.
- Complaints were received, triaged, acknowledged and disseminated to the divisions for investigation by the patient liaison manager on behalf of the Chief Executive.

Summary of findings

- Reports detailing numbers, performance, grading, subject, themes and learning on formal and informal complaints were received by the Trust board every six months. Quarterly patient feedback reports were presented to the Quality committee.
- The complaints policy had been reviewed in June 2014.
- A review of complaints was a standing agenda item on the division's governance meetings. There were number of examples provided across the trust of changes in practice as a result of complaints.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose.

Are services at this trust well-led?

Requires improvement

There remained significant challenges for the board in ensuring safer staffing levels this was identified in the board assurance framework and on the corporate risk register. The trust had developed safe nurse staffing escalation for in-patient areas policy the aim of the policy was to provide effective support to staff who had responsibility for safe nurse staff decision making on a shift by shift basis.

At the unannounced inspection in August 2015 we had serious concerns regarding the registered nurse staffing levels on Gates 20, 41, 42 and 43 which had impacted on the care patients received. Senior nursing staff within the trust who acknowledged at the time of the unannounced inspection the safe nurse staffing escalation policy had not been consistently used to support decisions about safe nurse staffing particularly the completion of the organisational risk assessments. As a result of our inspection and feedback the trust reported they had strengthened the process and these were reviewed by one of the deputy chief nurses each day. After the unannounced inspection we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards.

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

operating plan which translated the trust's strategies and five year integrated business plan. The two-year operating plan articulated what actions the division would take to ensure that the trust's strategic objectives were achieved.

Staff told us they felt the culture within the organisation had changed and that there was a desire to improve from the senior management team, management was better, communication had improved and there was more clinical engagement.

For further detail please refer to the individual location reports for the trust.

Vision and strategy

- The trust had a vision for the future called "meeting the challenge". This was detailed in the trust's five year strategic plan 2014/15- 2018/19.
- The aim of the vision was to provide integrated high-quality care at the right time and in the right place. The focus was to ensure that:
  - Patients are practically managed at or close to their homes.
  - Only those patients who need to be in hospital are admitted.
  - Once admitted into hospital, patients only stay for as long as is clinically necessary.
- The Transformation Programme was led by a partnership of the principal providers and commissioners of health and social care across the footprint of both Clinical Commissioning Group's (CCG's).
- The trust had developed an overarching strategy called "striving for excellence" which was detailed in the five year strategy. Underpinning the strategy there was five breakthrough aims which had key metrics against them so the trust could measure their performance against these.
- The divisions had developed a two year operating plan which translated the trust's strategies and five year integrated business plan. The two-year operating plan articulated what actions the division would take to ensure that the trust's strategic objectives were achieved.
- The Trust developed a Nursing and Midwifery Strategy in 2012 the strategy was for three years and had been recently reviewed and an update on the progress was presented to the trust board in June 2015. The vision articulated that 'nurses and midwives combine a compassionate care giving approach, with delivering personal, safe and effective services to anyone who needs them across the areas we serve'.

- The update to the strategy in spring 2015 highlighted how the strategy linked with other strategies within the organisation such as the patient and public engagement strategy and the quality improvement strategy.

Governance, risk management and quality measurement

- The trust had a board assurance framework (BAF) in place which was revised in January 2015 this identified the trust's strategic aims and objectives with key risks identified and described the responsibility and accountability for delivery. Risks were identified and key controls and gaps were identified.
- The board assurance framework was reviewed quarterly at the trust board meeting alongside the corporate risk register which included risks rated 15 or above. In addition the BAF was considered at every meeting of the risk management committee which was held monthly.
- The main risks on the register were with regard to the high level of registered nurse and care staff vacancies, non-achievement of the 2014/15 financial deficit plan approved by the Trust board and agreed with the trust development authority (TDA) and harm to patients caused by poor pressure ulcer prevention and management.
- There was a governance structure which informed the board of directors. This was developed and implemented in 2014.
- The trust had undertaken an annual review of trust leadership and management arrangements in April 2015 which highlighted there remained significant challenges for the board in ensuring safer staffing levels, delivering improvement in areas identified by the previous CQC inspection in July 2014 and embedding improvements in staff and patient engagement.
- The divisions in the trust had an integrated performance report which was structured around the five Care Quality Commission (CQC) domains, safe, caring, responsive, effective and well-led. The purpose of the monthly report was to identify and assess the division's performance against the key measures of quality, safety and sustainability against national and local targets.
- Following the announced inspection in June 2015 CQC received a number of concerns and on further analysis of other evidence an unannounced focussed inspection took place on the 25 August 2015 on Gates 20, 41, 42 and 43. The focus of the inspection related to staffing levels, missed patient care and poor experiences of care. At the inspection we had serious concerns regarding the registered nurse staffing levels on Gates 20, 41, 42 and 43 which had impacted on the care patients received. We found risk was not always well managed despite the identification of risk in relation to staffing.

Summary of findings

- After the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards. These included utilising staff within corporate nursing teams to support the wards each day with discharge planning and supporting patients with their nutritional needs and additional safety guardians and health care assistants.
- A risk summit was held following the unannounced inspection to look at what actions the trust needed to take to ensure safe staffing levels were achieved and what support was needed from the wider health community to support the trust with this. This meeting was chaired by NHS England. A health economy action plan was developed to support the trust to make the improvements they needed to ensure patients were protected from harm.
- The trust at the time of the unannounced inspection had 24 extra capacity beds open and this had impacted on staffing levels on other wards. The chief executive confirmed on 7 September 2015 all the extra capacity beds had closed and they would not admit to them in future unless they were part of a funded winter strategy and any beds used were safely staffed in accordance with the trust'snursing safety standards and escalation policies.
- We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward. Staff we spoke with confirmed the additional support they had been receiving since our unannounced inspection on 25 August 2015.
- At our inspection in July 2014 we found there had been a long standing issue over the age and effective use of equipment used in the pathology services and issues regarding the procurement process. Problems that had been experienced were frequent breakdowns and quality failures leading to potential risks to the accuracy of results.
- During this inspection we met with managers within the trust who told us new equipment had now been purchased for pathology (biochemistry and haematology) and would be in the trust from July 2015. There were planned dates for implementation on 5 November 2015 for biochemistry and January 2016 for haematology.

Summary of findings

- At our inspection in July 2014 we found there was a backlog in overdue outpatient appointments of 9,501. At this inspection the trust provided information on the outpatient backlog we saw in April 2015 the number was 3,716 in June 2015 this number was down to three patients.
- There had been a turnaround of the outpatient service which had included the standardisation of processes, following up of the backlog of outpatients, compliance with performance targets which included RTT and a restructuring across the other services.

Leadership of the trust

- The trust had a stable executive team there had recently been the recruitment of one non-executive director who had been a registered nurse, and one non-executive director who was a clinician, to strengthen the challenge to the board.
- There was a clear leadership structure within services from chief executive to ward levels. Staff within most services told us that since the last inspection in July 2014 they now had a secure management structures and staff.
- Staff told us following the concerns within outpatients the Chief Executive of the trust had got involved with the work to improve the service and this had changed the focus. The Chief executive attended weekly meetings about the service.
- There continued to be issues relating to the cohesiveness of certain surgical specialities. We found that the team remained dysfunctional without local consensus. Although there was no evidence to suggest individual clinicians were not caring for their patients, clinical engagement was not effective across all members of the team particularly across the Pinderfields and Dewsbury site. The trust had undertaken investigations (both internal and external) and was in the middle of an assessment however at present it was difficult to see full resolution.
- Within end of life services we found senior leaders did not have full awareness or understanding of the challenges of the service.

Culture within the trust

- Most of the staff we spoke with told us they felt the culture within the organisation had changed and that there was a desire to improve from the senior management team, management was better, communication had improved and there was more clinical engagement.

- Staff in outpatient reported they had felt valued by their managers and executives in the trust as they had received recognition and congratulations for the turnaround they had achieved.
- However in some services we found there were mixed messages about how open the culture was within the leadership team; staff felt some senior managers were not always visible.

Fit and proper persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation five of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensured that directors of NHS providers are fit and proper to carry out their role.
- A paper was submitted and approved by the Board on 11 February 2015 which set out the actions the trust would need to take to ensure compliance with Regulation five of the Health and Social Care Act (Regulated Activities) Regulations 2014. This set out the additional actions to the existing pre-employment checks that would need to be updated to reflect the regulation and the assurance process that would be implemented.
- Additional checks would include a search of insolvency and bankruptcy register, a search of disqualified director register and a self-declaration of fitness which included explanation of past conduct/character issues where appropriate.
- The trust had highlighted they would also include deputy directors as they would on occasions deputise for executive directors.
- We reviewed five files of the Executive and Non-Executive Directors and found the appropriate checks had been completed.

Public engagement

- There were strategies in place to understand the patient experience, learn from this and make improvements in service delivery. An integrated patient experience report in February 2015 highlighted key themes from patient feedback from a range of sources. The aim of this report was to identify areas of good practice and priorities for improvement to inform quality improvement and redesign work.
- The trust participated in national patient experience audits such as the friends and family test and national care of the dying audit.

Summary of findings

- The divisions within the trust had developed patient experience action plans and progress against these action plans were reported into the quality committee.
- The trust has plans in place to present patient stories to the trust board from February 2016.

Staff engagement

- Across services in the trust listening into action (LIA) events had been held these were called the "big conversation". LIA was a programme which supports staff to transform their services by removing barriers that get in the way of providing the best care to patients and their families.
- Overall in the NHS staff survey 2014 the trust had two positive findings and 13 negative findings compared to the national averages. The latest results showed the trust had improved scores on 59 questions compared to the results in the 2013 survey.
- Staff survey results for the whole Trust showed that 77% of staff felt satisfied with the quality of work and patient care they were able to deliver compared to a national average of 78%.
- The trust had re-launched the MY Star awards and had also been revising the celebrating success event following feedback staff gave about changes they wanted to see. We saw employee or "star" of the month were awarded to staff on the wards.

Overview of ratings

Our ratings for Pinderfields Hospital

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

Overview of ratings

Our ratings for Dewsbury and District Hospital

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

Overview of ratings

Our ratings for Pontefract Hospital

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

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for The Mid Yorkshire Hospitals NHS Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the trust MUST take to improve

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

Outstanding practice and areas for improvement

- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users.
- The trust must ensure there are improvements in the number of fractured neck of femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours.
- The trust must improve process the discharge patients who may be entering a terminal phase of illness with only a short prognosis.
- The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

In addition the trust should:

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- The trust should ensure staff are involved and informed of service changes and re-design.
- The trust should take actions to address the historical management–clinician divides that had not been resolved amongst certain surgical specialities.
- The trust should ensure in community inpatient services there is a referral criteria for the service and in-reach assessments are carried out consistently to improve the admission and referral process.
- The trust should ensure toilet facilities in community inpatient services are designated same sex, in order to comply with the government's requirement of Dignity in Care.
- The trust should ensure care and treatment of service users is only provided with the consent of the relevant person.
- The trust should ensure patients receive person-centred care and are treated with dignity and respect.
- The trust should ensure the equipment and premises are suitable for the purpose for which they are being used and are appropriately maintained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1), (2 a, b, d, e, f, g, h) Safe care and treatment The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines, oxygen is prescribed in line with national guidance. The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment. The trust must ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented. The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients. The trust must ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours.

This section is primarily information for the provider

Requirement notices

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 Meeting nutritional and hydration needs (2 a) (4 a, b, c, d).

The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are met.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance (2 a, b, f) (3 b)

This section is primarily information for the provider

Requirement notices

The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.

The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.

The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board.

The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed.

The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

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

This section is primarily information for the provider

Requirement notices

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