The Mid Yorkshire Hospitals NHS Trust

Dewsbury and District Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

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

The acute services are provided in three hospitals, Pinderfields Hospital, Dewsbury District Hospital and Pontefract Hospital. Dewsbury District Hospital is situated in Dewsbury and serves a population of 422,458 with approximately 358 beds.

There were plans in progress for the reconfiguration of services at the trust with the aim of centralising children's services; consultant led maternity services and acute emergency services at Pinderfields Hospital. This had caused a level of anxiety amongst both the local population and the staff working at the trust. This new clinical strategy was subject to consultation.

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

Overall, we rated Dewsbury District Hospital as requires improvement. We rated it inadequate for safety. We rated it good for caring and required improvement for effective, responsiveness and well-led.

We rated critical care services as good. Accident and emergency, medical care, surgery, maternity, end of life care and children and young people's services were rated as requires improvement. We rated outpatients as inadequate.

Our key findings were as follows:

We observed areas of good practice including:

- Generally patients being cared for on the wards gave positive feedback about their experiences.
- There were arrangements in place to manage and monitor the prevention and control of infection. We found all areas we visited to be visibly clean.

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

Importantly, the trust must:

- Ensure that the reporting of performance, risk and unsafe care and treatment is robust and timely to the Trust Board so that appropriate decisions can be made and actions taken to address or mitigate risk to patient safety.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Address the backlog of outpatient appointments, including follow-ups, to ensure patients are not waiting considerable amounts of time for assessment and/or treatment.
- Ensure clinical deteriorations in the patient's condition are monitored and acted upon for patients who are in the backlog of outpatient appointments.
- Review the 'did not attend' in outpatients' clinics and put in steps to address issues identified.
- Ensure the procedures for documenting the involvement of patients and relatives in 'Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) are in accordance with national guidance and best practice at all times.
- Ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- Ensure recommendations from serious incidents and never events are monitored to ensure changes to practice are implemented and sustained in the long term.
- Ensure there are improvements in referral to treatment times to meet national standards

Summary of findings

- Review the skills and experience of staff working with children in the A&E departments, special care baby unit and children's outpatients' clinics to meet national and best practice recommendations.
- Ensure staff are clear about which procedures to follow in relation to assessing capacity and consent for patients who may have variable mental capacity. This would ensure staff act in the best interests of the patient in accordance with the Mental Capacity Act 2005 and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure all staff attend and complete mandatory training and role specific training, particularly for resuscitation and safeguarding; staff working in urgent care settings where appropriate undertake level 3 safeguarding training.
- Ensure staff receive training on caring for patients living with dementia in clinical areas where patients living with dementia access services. In addition, where appropriate ensure staff are trained on the End of Life care plan booklet and updated on the trust's new policy.
- Ensure that issues with replacing pathology equipment are addressed to ensure that equipment is fit for purpose.
- Ensure the pharmacy department is able to deliver an adequate clinical pharmacy service to all wards.
- Ensure staff are trained and competent with medication storage, handling and administration.
- Ensure controlled drugs are administered, stored and disposed of in accordance with trust policy, national guidance and legislation.
- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) are embedded in theatre practice.
- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours
- Ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Ensure the recommendations from the mortuary review are implemented and monitored to ensure compliance.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.
- Ensure actions are taken to address the poor decorative state of the mortuary to ensure effective and thorough cleaning can be undertaken at Dewsbury and District Hospital.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated caring and being well led as good. Improvements were required with safety and responsiveness. We did not rate effectiveness. The A&E department was clean, with arrangements in place for the prevention and control of infection. There were systems in place to manage deteriorating patients. Staff learnt from incidents, although some medical staff felt feedback could at times be ad hoc. Staffing levels, including skill mix did not meet national and best practice guidance, particularly with the children's service. Arrangements had been put in place to ensure that children's needs were safely managed. Recruitment was actively taking place. Not all staff had completed mandatory training including safeguarding children, and there was limited knowledge over the assessment of a patients mental capacity. Care and treatment was provided in line with national and best practice guidance. Patients were positive about the care and treatment received However, the trust had identified the time patients were waiting in A&E to be handed over from the ambulance staff was a concern since June 2013. The issue of handover times was discussed subsequently throughout the year. Despite some improvements during the course of the year, in April 2014 it was noted that ambulance handovers remained a problem. Generally the trust was meeting the 95% target for patients being treated within four hours in A&E however there were some occasions when they didn't meet this. Staff reported there was strong leadership in the department and staff were supported to raise concerns. We saw good team working across disciplines and staff were trained and supported effectively
Medical care	Requires improvement 	We rated medicine as inadequate for safety and being well led. Improvements were required for effectiveness and being responsive. We found caring to be good.

Summary of findings

We found the medical wards were clean and well maintained with arrangements in place for the prevention and control of infection. Staff were reporting incidents, which was encouraged by the trust. There were mechanisms in place to manage and monitor incidents. However, the medicine division was performing worse than the average for pressure sores and catheter-acquired infections. Staff shortages meant that the staffing levels and skill mix was not meeting national and best practice guidance, which impacted negatively on the care experienced by patients. The trust was using a significant number of temporary staff, including agency and locum medical staff. The appropriate arrangements were not always in place for dealing with medication. Not all staff were fully up to date with their mandatory training.

Treatment was in accordance with best practice and national guidance. Access to diagnostic services was provided seven days a week, although some patients had to wait over a weekend to access some tests and scans. Generally, patient feedback was positive about care received. Interpreting services were available, but there was little patient information available in different languages.

Clinical audits took place to ensure that staff were working to expected standards and following guidelines, although some areas needed improvements Access to diagnostic services was provided seven days a week, although some patients had to wait over a weekend to access some tests and scans.

Interpreting services were available, but there was little patient information available in different languages.

The medical division had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. Patient and staff engagement was improving. We had concerns that although the medical division was aware of many of the risks we identified, insufficient action had been taken to adequately address them.

Surgery **Requires improvement**

We rated surgical services as good for caring, but improvements were required for safety, effectiveness and well led. We had serious concerns

Summary of findings

over the number of patients waiting to be admitted for treatment (the target for the referral to treatment at 18 weeks was not being met) at times the access and flow of patients on the wards and in theatres were ineffective and there were delays in sending discharge letters to GPs.

There were effective arrangements in place for reporting incidents and staffs were encouraged to report them. Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Appropriate staffing levels and skill mix across all surgical services were not always sustained at all times of the day and night.

There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. However, the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completely embedded in theatres and daily checks of equipment were not consistently carried out. Staff awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were limited.

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges. Other indicators showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, and the number of emergency admissions following elective admissions.

The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (CEPOD). However, there was no dedicated emergency surgical CEPOD theatre, which meant that there was a risk that urgent cases would not be dealt with in a timely manner putting patients at risk.

We observed positive, kind and care provided to patients and most patients felt they understood their care options and were given enough information about their condition.

Surgery had systems in place to plan and deliver services to meet the needs of local people. The trust

Summary of findings

had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. We found that staff were responsive to people's individual needs, but that there were serious concerns over waiting times, such as the 18-week referral to treatment times, waiting for care once in hospital and the high number of medical outliers on surgical wards. There was good ward leadership and staff felt supported and had seen positive changes in some areas to improve patient care. Some staff reported a 'disconnect' between middle management and themselves, and felt there was a lack of communication and flexibility to support autonomous working. There were changes in management structures and reconfiguration of services that had led to low staff morale, particularly in theatres.

Critical care

Good

We rated the services for critical care as good, although improvement was required for safety. There were systems, processes and practices in place to keep patients safe that were generally reliable. However, nursing and medical staffing levels were not always in line with the 'Core Standards for Intensive Care Units' and the daily monitoring of equipment was not consistently carried out.

The assessment, care and treatment of patients were delivered in line with current national standards and recognised evidence-based guidance. This included patient care in line with the national core standards for critical care units and National Institute for Health and Care Excellence (NICE) guidance. The care and treatment delivered achieved positive outcomes for patients. Outcomes were routinely monitored and measured, shared internally and externally, and used to make improvements to the service.

There was effective communication between the multidisciplinary team, appropriate and effective use of the critical care outreach team and the support given to patients and their families.

Patients and their families were positive about the care and treatment in the critical care unit. Patients were treated with compassion and respect and

their privacy and dignity were maintained. As far as possible, patients were involved in making decisions about their care and treatment. Patients' families and visitors were treated with consideration and respect.
The service was responsive to the needs of patients and had caring staff. There was appropriate provision of critical care services to meet the needs of local people. Access to the critical care unit was based on clinical need, including patients who needed planned critical care following elective surgery. There was a low rate of cancellation of planned surgery arising from a lack of beds in the critical care unit.
Staff were positive about the leadership within the critical care service. They felt that their managers were in touch with the challenges faced by the service. Most staff felt there should be more visibility of the chief executive and the executive team. Risks were identified, understood and were being managed. This included risks around staffing and the environment of the critical care unit.

Maternity and gynaecology — **Requires improvement**

We rated the maternity service as good for effectiveness, being responsive and caring, but improvements were required for safety and well led. Most areas of the maternity unit were visibly clean; surfaces in the delivery suite required attention. There were effective systems in place to monitor infection control. Staffing levels did not meet best practice and national guidance. Records were not consistently completed and updated. Medical and midwifery staff reported delays in recruitment processes trust-wide and this included anaesthetists. We found the birth to midwife ratio was 1:33; the national guidance was 1:28. We were informed that 13 midwife appointments had been made the previous week and would be in post by October 2014, which would bring the birth to midwife ratio down to a ratio of 1:31.
We found staff did not always check emergency equipment daily to ensure it was available in the event of an emergency situation.
Women received care according to professional best practice clinical guidelines and audits were carried out to ensure staff followed recognised national guidance. However we saw information in the

Summary of findings

external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were obese or morbidly obese, and one was overweight. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.
Staff were reported as kind and understanding. The service ensured women received accessible, individualised care, while respecting their needs and wishes.
The service was well-led at unit level and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service. Staff reported that they had several changes in managers in the last five years, with more changes planned in the near future. There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives.
An external review had been commissioned as there had been a cluster of eight serious incidents in a short space of time. Concerns previously raised in 2011 and 2012 had resulted in a number of actions; it was not clear how these actions had been monitored by the trust to ensure the service had acted on identified concerns and sustained improvements in practice.

Services for children and young people

Requires improvement

We rated the safety and responsiveness of children's services as requires improvement. We found that care was good; children's services were effective and were well led
We found all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. There were incident reporting mechanisms in place. At ward and unit level risks were regularly assessed and monitored, with control measures in place. However, we found there was confusion over version control on risk registers.
We found ward seven was staffed sufficiently to meet the needs of children and families. However, staffing of the children's outpatient department was not satisfactory because there was not always

a readily available registered children's nurse to oversee the clinics and staff were not aware of any protocol to adequately access staffing, advice and support when needed.
Children, young people and parents told us they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to their treatment and care.
The trust was in the process of reconfiguring inpatient services at Dewsbury and Pinderfields Hospitals, which met national guidelines for the centralisation of children's inpatient services.
During our review we found there was a lack of clarity on the potential responsiveness of service delivery after implementation of the change, which was to take place shortly. The service did not currently have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes.
We found that children's services were well led at ward and unit level with. There were governance processes in place. There was a culture of openness and flexibility at ward and unit level that placed the child and family at the centre of decision-making processes. However, there was no nominated executive and non-executive director at board level to champion children's rights.

End of life care — **Requires improvement**

We rated end of life services inadequate for safety, with improvements required for effectiveness, responsiveness and being well-led. We found caring to be good.
End of life care was provided in most areas in the hospital and there was a palliative care team to support staff and give advice. Staff were committed to providing a compassionate service but shortages of staff were impacting on the safety and quality of care given. Staff reported incidents, but these were not consistently reported and timely. Actions from incident investigations did not always lead to changes in practice.

Summary of findings

The trust had introduced end of life records, but there was no clear pathway for staff to follow, although one was being developed. There were inconsistencies in record keeping including decisions over whether to resuscitate.
Whilst some staff told us they had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, they displayed a poor knowledge of how this should be applied in practice. This did not ensure patients were appropriately supported to make decisions and that decisions were being made in their best interests.
Patients referred to the specialist palliative care team were seen promptly according to their needs. The specialist palliative care team were committed to ensuring patients receiving end of life care had a positive experience. Bereavement staff supported families effectively, although the chaplaincy services were under pressure to meet demand. Staff communication over the service review at Dewsbury Hospital was poor.
Training on end of life care was not mandatory and staff struggled to attend specialist meetings. There were inconsistent practices across hospital sites and a concern over staff failure to adopt trust policies and procedures. There was no clear faith strategy or vision or end of life champion at Board level.

Outpatients and diagnostic imaging

Inadequate

We rated outpatients as inadequate for safety and being responsive, caring we rated as good and we rated well led as requiring improvement. We did not rate the effectiveness of the service. There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for assessment and treatment. There had been a validation process in place, which had reduced the numbers waiting, but this had not addressed the risks to patients whose condition may be deteriorating.
There were two separate arrangements in place to manage outpatients clinics, a central system and a system which was directly led by the specialties. The systems operated in different ways. Incidents were reported but learning from these was not always shared so that improvements could be

Summary of findings

made. Outpatient areas were clean and well maintained with measures in place for the prevention and control of infection. Staff rotated across all three hospital sites depending on need and demand of the service. Outpatient clinics were, in general, comfortable and friendly, with suitable facilities. Essential equipment was not always easily available such as wheelchairs and blood pressure monitors.

Within clinics, staff treated patients with dignity and respect. Patients told us that they were very satisfied with the service they received. However, there were high numbers of complaints going back many months reporting distress and frustration at delays in accessing appointments, multiple cancellations of appointments, changes in location of appointments and the poor communication with the services.

We found audit data in relation to clinic cancellations and delays was available. When we spoke to the manager we were told data was inaccurate and unreliable due to the new PAS system issues. Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%. The trust was unable to give reasons for this. Analysis of data showed from February 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients.

Dewsbury and District Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

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Detailed findings

Background to Dewsbury and District Hospital

Dewsbury District Hospital is part of the Mid-Yorkshire NHS Trust. It is situated in Wakefield and serves a population of 422,458 people in the local area. The hospital has approximately 358 beds.

The trust employs around 8,060 members of staff including 755 medical & dental staff.

Dewsbury District Hospital provides a range of services including: Accident and Emergency, Neonatal Intensive and High Dependency Care, a range of general and specialist medicine services for adults, care for children with surgical and medical problems (children's ward), surgery for adults including general surgery, gynaecology, cancer, orthopaedics, ear, nose and throat (ENT), urology, vascular, Intensive Care and High Dependency Units, Consultant Led Maternity Service with Neonatal Intensive and High Dependency Care and Special Care, Day surgery for adults and children, outpatient services for adults and children and rehabilitation and Therapy Services.

The inspection team inspected the following eight core services at Dewsbury District Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatient services

Dewsbury District Hospital was inspected in May 2013 inspection and the hospital did not meet the standards for respecting and involving people who use the services, staffing and assessing and monitoring the quality of service provision.

Our inspection team

Our inspection team was led by:

Chair: Dr Bill Cunliffe

Team Leader: Julie Walton, Head of Hospital Inspection, CQC

The team included CQC inspectors and a variety of specialists including medical consultants, junior doctors, senior managers, nurses, midwives, paramedics, palliative care nurse specialist, a health visitor, allied health professionals, children's nurses, school nurse and experts by experience who had experiencing of using services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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 hospital. These included the clinical commissioning group (CCG), the Trust Development Authority (TDA), NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Wakefield 14 July 2014, where 35 people shared their views and

Detailed findings

experiences of the Mid-Yorkshire Hospitals NHS Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups in Dewsbury and Wakefield to hear people's views and experiences.

We carried out the announced inspection visit between 15 and 18 July 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection in the evening on 27 July 2014.

Facts and data about Dewsbury and District Hospital

In 2012 -13, Mid-Yorkshire NHS Trust had a total of 153,990 inpatient admissions, 456,169 outpatient attendances and 226,583 attendances at the Accident & Emergency departments.

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

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Urgent and emergency services

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

Information about the service

There were 92,879 attendances in the accident and emergency department (A&E) between May 2013 and May 2014 at Dewsbury District Hospital, of which 25,180 were by children (under 18 years old). Children had their own waiting and treatment area that was secure. The hospital did not provide ambulatory emergency care; this was provided at Pinderfields General Hospital.

In the adult A&E there were two assessment cubicles and 14 trolley cubicles. The trolley cubicles were divided into two bays with six and eight beds respectively. The resuscitation area was able to care for four patients; this included one resuscitation trolley area that was equipped for the care of children. Mobile x-rays were available for acutely ill patients, although patients requiring a full trauma series of x-rays were stabilised and moved to the x-ray department when appropriate. The children's area could care for three children on trolleys and had a waiting area with ten chairs. It was suitably equipped with toys.

Mobile patients were initially assessed when booking in at reception and directed to the most appropriate area. Minor injuries were treated by another organisation between the hours of 9am and 8pm Mondays to Fridays and 10am and 6pm on Saturdays and Sundays.

The hospital did not receive any major trauma injuries; patients were transported to Pinderfields General Hospital. Another hospital in the region received all major trauma cases and had been the designated major trauma centre for West Yorkshire since April 2013. Patients were also transported to another hospital in the region when they had suffered severe heart attacks or leaking aortic aneurysms and required specialist care.

Urgent and emergency services

Summary of findings

We rated caring and being well led as good. Improvements were required with safety and responsiveness. We did not rate effectiveness.

The A&E department was clean, with arrangements in place for the prevention and control of infection. There were systems in place to manage deteriorating patients. Staff learnt from incidents, although some medical staff felt feedback could at times be inconsistent. Staffing levels, including skill mix did not meet national and best practice guidance, particularly with the children's service. Arrangements had been put in place to ensure that children's needs were safely managed. Recruitment was actively taking place. Not all staff had completed mandatory training including safeguarding children, and there was limited knowledge over the assessment of a patient's mental capacity.

Care and treatment was provided in line with national and best practice guidance. Patients were positive about the care and treatment received.

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

Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. Further protocols were being developed. Assessment of pain was undertaken as part of the admission process and dealt with as quickly as possible. Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so.

Staff reported there was strong leadership in the department and staff were supported to raise concerns. We saw good team working across disciplines and staff were trained and supported effectively.

Are urgent and emergency services safe?

Requires improvement

The A&E department was clean with infection prevention and control arrangements in place. Equipment was checked regularly and there were systems in place to manage deteriorating patients.

Staff reported that they learnt from incidents in the department, although Some medical staff felt feedback could be ad-hoc at times. Patient records were kept securely and consent was gained from patients before procedures were undertaken. However, staff awareness over the procedures for assessing mental capacity with regard to consent was limited.

Staff knew how to raise concerns about adults and children who may be at risk from harm. However, not all staff were trained to the appropriate level for safeguarding children. Not all staff had completed their mandatory or role specific training.

The department had four substantive consultant posts and three locum posts. This was below the recommendation by the Royal College of Emergency Medicine. A consultant was on-call overnight and at weekends. Agency nursing staff were used on a regular basis, although five new members of nursing staff had recently been recruited. Children's nurses were available during day hours; this was due to be extended to midnight. There were no qualified paediatric emergency medicine consultants available in the department; the emergency medicine service had a Trust wide paediatric emergency medicine lead based at Pinderfields Hospital. One consultant working in the department had a special interest in paediatric medicine and the department liaised with the paediatric emergency medicine lead at Pinderfields Hospital when necessary.

The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children's nurse on each shift. The department had four qualified children's nurses who worked between the hours of 9am-9.30pm. This meant the department was not working within the standards for children and young people in emergency care settings.

Urgent and emergency services

Incidents

- Staff knew how to report incidents on the electronic Datix system and could give examples of when they had done so. Staff confirmed they always reported incidents.
- Nursing staff reported that individual feedback on incidents was given by the lead nurse; doctors reported this could be more of an ad-hoc arrangement.
- At the time of our visit the lead nurse investigated all Datix incidents. This was due to be changed so that the senior nurse in each of the areas of the department would investigate their own incidents.
- We saw the number of Datix incidents for June 2014, which amounted to 33 across 31 different categories, including wrong diagnosis and lack of suitably trained/ skilled staff. The data did not raise any themes.
- Learning from incidents took place every month via a multidisciplinary team meeting and through a monthly staff newsletter -'Big ED', which had commenced in June 2014. This was distributed to all three A&E departments in the trust. We saw a laminated copy available on a notice board.
- Emails were sent to departments in response to investigations to alert staff of the findings and a communication book was in use to ensure immediate lessons from each shift could be documented and read. Staff stated they read it on a regular basis.
- Although all A&E deaths within 24 hours of admission were discussed at their monthly clinical governance meeting, this was only attended by senior nurses and doctors, and a full review of individual cases; minutes were not taken to record the meeting's discussion.

Safety thermometer

- The A&E did not have its own patient safety information displayed in the department. However, individual audits, for example hand hygiene, were visible.
- We were informed some work was about to begin that would address the issue.

Cleanliness, infection control and hygiene

- Areas were clean and odour-free. Surfaces and mattresses were clean, and we observed thorough cleaning of equipment and trolleys by all grades of staff.
- 'I am Clean' stickers were seen in use. Hand washing facilities and alcohol gel were available in all areas and staff were seen to use them automatically.
- The monthly hand hygiene result for the previous month in the department was reported as 100%. An audit of cannula insertion had a return rate of 90% because documentation was not completed.
- All trust staff were observed to be compliant with the "bare below the elbow" policy.
- There was only one specific area for isolation used within the department. This had walls and a door. If further space was required then a walled cubicle would be used. After use areas were deep cleaned and cubicle curtains changed.
- Infection prevention and control was part of mandatory training for all members of staff.
- Domestic staff were in the department from 7.30am until 8.30pm and were responsible for removing clinical waste.
- Clinical waste and sharps containers were seen to be below the maximum levels.
- If a patient with a known Methicillin-resistant Staphylococcus Aureus (MRSA) or Clostridium difficile infection attended A&E, all staff were notified and suitable precautions taken.
- Toilets were clean and well maintained.

Environment and equipment

- All trolley bay areas were appropriately equipped for treating ill patients and contained cardiac monitors and suction machines.
- There was sufficient equipment for monitoring and treating all patients, for example infusion pumps.
- Bariatric equipment was available and accessible in A&E when required.
- Any faulty equipment was taken out of use, labelled as such and reported, and a log number obtained.
- Equipment and linen stores were well stocked, labelled and accessible to staff.
- The equipment we saw had been serviced and was in working order.
- Resuscitation equipment was appropriate and checked daily with regular auditing.

Medicines

- Patients with any known allergies to drugs were identified during the triage process. A note was made on the patient's record.
- We looked at the way the department kept their controlled drugs. Controlled drugs were checked regularly, although the department's bottle of Oramorph was not dated on opening.

- There were processes in place for storing and administering medication appropriately.
- Intravenous fluids were stored alphabetically for ease of use.
- The medication charts we looked at were found to be signed and dated correctly.
- Medication fridges were the correct temperature and checked three times a week by the hospital pharmacy team. They were kept locked appropriately.
- Medicines for patients to take home were well organised and only issued after 5pm, when the pharmacy in the hospital closed.

Records

- Patient's records were kept securely and were only accessible to healthcare professionals.
- Documentation for the assessment of patients was completed for all new patients in A&E with an initial front sheet created by the reception team.
- Vital signs, such as temperature, blood pressure and pulse, were recorded. Analgesia (pain-relieving medicine) was prescribed when necessary.
- The A&E admission pro-forma had no areas for identifying risks to patients, for example falls. We were informed clinicians and nurses used their own professional judgement to identify if someone was at any particular risk. If they were, the appropriate risk assessments would be completed. We saw falls and pressure ulcer risk assessments had been recorded for older people in A&E, including recording a Waterlow score used as part of pressure ulcer risk assessments.
- Notes from previous admissions could be obtained electronically within a few minutes or in paper format. A&E notes were scanned and uploaded on a regular basis and made available to hospital staff. Paper records were then shredded.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients who required procedures under an anaesthetic had their written consent obtained before the process was undertaken.
- Patients told us they were asked for their verbal consent before procedures were undertaken.
- There was no documentation to support or assist clinicians in assessing a person's mental capacity, although this was available on the trust's intranet.
- Four members of staff were aware of the Mental Capacity Act 2005, although they were not aware of a trust policy. When we spoke with the lead nurse for A&E, they informed us they were aware further training was required with regard to the Mental Capacity Act 2005 and they were in the process of accessing it.

Safeguarding

- Staff were aware of the trust's safeguarding procedures for adults and children, what constituted abuse and how to report tithe trust's electronic system automatically prompted safeguarding questions when children presented in the A&E department.
- There was a clear pathway in place for any potential non-accidental injuries to children. Children would be referred directly to the paediatric team.
- Any children presenting at any of the three A&E departments in the trust more than three times were seen by a senior doctor and automatically referred to the health visitor.
- There was a system in place for alerting staff in the department about any children who social services had concerns about. This ensured social services staff were alerted if the child attended A&E.
- Level 3 safeguarding training, which included children, was mandatory for nursing staff. Records showed 75% of nurses were trained at level 3. All middle-grade doctors had level 2 training; more senior doctors had level 3. The Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate document March 2014 states all staff working in urgent care settings should undertake level 3 safeguarding training. The document further specifies that this relates to medical and registered nursing staff who work in Accident and Emergency departments, urgent care centres minor injury/illness units and walk in centres. This meant the department did not ensure staff were trained to the appropriate level for safeguarding children.
- There is a trust safeguarding lead and staff in the department were aware of this.

Mandatory training

- Mandatory training was actively encouraged in the department. The mandatory training matrix for the division showed 91% of staff had attended core mandatory training against a target of 95% and 72% had attended role specific mandatory training against a target of 80%.

- The training was mainly provided via e-learning, although some elements, for example fire training and conflict resolution, were undertaken on a face-to-face basis.
- Staff were individually responsible for completing their own mandatory training, but this could be hindered by not having available time to complete it during their shifts.
- Staff were allocated one day on an annual basis to complete the training.
- The trust's mandatory training included infection control, health and safety and safeguarding.
- A member of staff informed us some staff fell behind with the training because of lack of time, sickness and occasionally disengagement. However, staff were reminded of its importance and the implications of non-compliance.
- The mandatory training matrix for the division showed 91% of staff had attended core mandatory training against a target of 95% and 72% had attended role specific mandatory training against a target of 80%. The lead nurse was aware of staff who had not completed some of the annual elements and was actively ensuring this was undertaken.

Initial assessment and treatment

- Patients who walked into the department were booked in by the receptionist. Patients were streamed according to their presenting complaint using a set of criteria.
- If a patient presented with certain conditions, for example chest pain, they were immediately directed into the majors' area A&E.
- An initial assessment or triage of each patient was undertaken by a nurse and healthcare assistant.
- Patients transported to A&E by ambulance were transferred directly into the department and there was a dedicated receptionist to take patient details and direct the patient to an assessment cubicle.
- There were care bundles and flow charts in place for specific conditions such as asthma, chronic obstructive pulmonary disease and sepsis.

Assessing and responding to patient risk

- Following a patient's initial assessment, observations such as temperature, pulse and blood pressure were recorded on the computer system, which created a National Early Warning Score automatically. If scores were elevated (over 4), senior support was immediately sought.
- The National Early Warning Score is a simple, physiological score and its primary purpose is to prevent delay in intervention or transfer of critically ill patients.
- Reception staff could observe patients in the waiting room during the course of their shift. If they were concerned about a patient, they alerted nursing staff.
- Patients with serious trauma injuries were taken to Pinderfields Hospital. For patients requiring transfer to Pinderfields Hospital or a hospital providing specialty services, the department organised this.
- The trust had standard operating procedures in place for managing emergency demand in any of the hospitals to ensure risks to patients were minimised.
- The A&E department regularly received patients requiring admission to the hospital from GP referrals. We were informed on an average day this could mean three or four patients in the afternoon. On occasions this could rise to 12, meaning the capacity of the A&E department was reduced accordingly.

Nursing staffing

- The department had undertaken a staffing review. Results from the review were ready to be implemented. The lead clinician informed us the nursing establishment levels the A&E now aspired to be based on papers written for emergency departments in San Francisco and New Zealand.
- The department had recently recruited to five Band 5 posts and was waiting for their employment to begin.
- We looked at three months of duty between April and June 2014. Staff informed us bank and agency nurses were regularly used to fill the shortages. During a 24-hour period the numbers of registered nurses varied between nine in the afternoon and six at night. This included staffing of the paediatric area. There were three healthcare support workers on duty during the day and one at night.
- A comprehensive induction programme was in place for newly appointed staff, followed by a competency programme to ensure staff acquired the skills required to work in A&E.
- Staff felt well supported by the lead nurse in A&E.
- The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children's nurse on each shift. The department had four qualified children's nurses. The

aim of the department was to always have a children's nurse on duty between the hours of 9am and 9.30pm however this did not meet the standards from the Royal college of Paediatrics and Child Health.
- Information showed over the previous two years children were attending A&E later in the evenings. Consideration was being given to increasing the availability of a children's nurse until 12 midnight as soon as possible, although shifts patterns were an obstacle to implementing this. At night we found there was always a nurse on duty with experience of nursing children but not a registered children's nurse. However even with these changes, this would still mean the department was not working within the standards for children and young people in emergency care settings.
- Twelve nurses had been trained in paediatric life support.
- The department was proactive in managing sickness levels, which were at 4%. This had been as low as 2% two months earlier.
- A noticeboard to alert patients to the numbers of rostered and actual staff on duty was due to be erected within a week.

Medical staffing

- The Royal College of Emergency Medicine recommends 12 specialist consultants for an A&E department seeing between 80,000 and 100,000 patients per year. Dewsbury A&E department saw 92,879 for the period May 2013 and May 2014.
- The department had four substantive consultant posts and three locum posts. This was below the recommendation by the Royal College of Emergency Medicine. They worked between 8am and 9pm Monday to Fridays and 9am and 5pm at weekends. A consultant was on-call overnight and at weekends.
- We were informed recruitment was in progress for an additional four consultant posts to work across all the trust's A&E sites. In addition, funding had been agreed for three further posts in the expansion plan for the department.
- A senior middle-grade doctor was in the department overnight. Junior doctors were also available. Locums were used to fill gaps in the middle-grade rota; where possible these were either long-term appointments or locums who had previously worked in A&E.
- At the time of our visit there was no consultant with specific paediatric qualifications available in A&E, although funding for two posts within the trust had been confirmed and an advert was due to be published.
- One consultant working in the department had a special interest in paediatric medicine. We were informed the department could liaise with the paediatric emergency medicine consultant at Pinderfields District Hospital when necessary.
- Registrars rotated between Dewsbury and Pinderfields.
- We were informed by a senior member of staff that when the new paediatric assessment unit was opened a paediatrician will be available to give support to the paediatric A&E.

Major incident awareness and training

- There was a major incident policy in place for use by the department.
- A trust-wide emergency training day had been held within the last 18 months, but ongoing building work had prevented the department from holding it again.
- Major incident equipment cupboards were well stocked and accessible.
- We saw the decontamination suite in A&E. This was used for patients who were contaminated with chemical, nuclear or biological agents. A shower was available and we saw patients could be brought straight into the suite from the car park if necessary, which would prevent contaminating other patients or staff.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. Assessment of pain was undertaken as part of the admission process and dealt with as quickly as possible. Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so.

Urgent and emergency services

Patients were confident in the staff's ability to deliver high-quality care. We saw good team working across disciplines and staff were trained and supported effectively.

Evidence-based care and treatment

- The A&E was managed effectively and in accordance with the clinical standards for emergency departments.
- We saw there were protocols in place for dealing with patients with particular problems, for example infections and heart attacks. They all related to guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine.
- We also saw the protocols for the management of strokes and fractured necks of femur.

Pain relief

- An assessment of pain was undertaken on a patient's arrival in the hospital as part of the admission process.
- Patients were witnessed to have their pain assessed in a timely manner and offered pain relief.
- We spoke with one patient who had been administered pain relief on arrival but was still in pain. We returned two hours later to find they had received additional pain relief and was much more comfortable. Documentation had been completed to reflect this.
- We did not see any other patient in pain during our inspection.

Nutrition and hydration

- Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so. We heard patients being offered this.
- If patients had to stay in the department overnight because of a lack of beds in the hospital, the catering team provided meals.
- Vending machines selling coffee and snacks had recently been installed in the waiting room.
- Older people were assisted to take food and fluids if this was required.

Patient outcomes

- Unplanned re-attendance rates within seven days across the three A&E departments for the trust were higher than the England average. This was running at 7.5% and 8% compared with the standard rate of 5%.
- When patients had to stay in the department overnight, the doctor receiving the patient after leaving A&E would attend the department and ensure their care continued seamlessly.
- Feedback from the College of Emergency Medicine showed the hospital had not taken part in consultant sign-off data since 2012.
- Feedback from the College of Emergency Medicine showed the A&E department had taken part in their audits since 2008, including asthma, pain in children and renal colic.

Competent staff

- Patients felt very confident in the staff's ability to care for them appropriately.
- Nursing staff felt competent to undertake their role and told us they had opportunities to develop their knowledge and skills.
- Staff were aware of national guidance for particular illnesses, for example pleuritic chest pain.
- 80%of staff across the emergency departments had received up to date resuscitation training.
- Nurses qualified to care for adults were encouraged to complete a structured course about nursing sick children in A&E. Twelve had completed the course and more will be completing it when one becomes available locally.
- Medical staff felt supported in their role by line managers.
- We spoke with a junior doctor who told us they felt the department was a good learning environment and had received support from their consultant and middle-grade doctors. They told us they would recommend Dewsbury A&E as a place to work and study.
- Staff we spoke with had received annual appraisals. The time was also used to identify training needs and discuss development opportunities. Data we received showed the division of medicine, which includes A&E, had only achieved 56.6% of appraisals for all staff across all the trust's hospitals.
- Staff could attend peer-led awareness sessions to discuss particular topics.

Multidisciplinary working

- We witnessed excellent interactions between doctors and nurses during the inspection.

Urgent and emergency services

- Staff in the department informed us the internal multidisciplinary working, for example between specialties, was generally good.
- We saw the working relationship between staff in the minor injuries unit and A&E staff. Staff for both providers were supportive of each other.
- Liaison between the staff in x-ray and the scanning facilities was good and blood samples were reported on quickly.
- Discharge letters were constructed electronically and printed off to either be sent by post to their GP or given to the patient to deliver.
- Patients requiring referral to psychiatric services were generally seen within two hours by the crisis team.
- We saw information available for patients requiring specialist services, for example on alcohol misuse and advice regarding the early pregnancy assessment unit, which was available at both Dewsbury and Pinderfields Hospitals.

Are urgent and emergency services caring?

Good

Patients felt they were listened to by health professionals and were involved in their treatment and care. We saw examples of excellent caring and compassionate interactions with patients given in a quiet and dignified manner.

Staff were aware of the different cultural needs of the local community, particularly in relation to the grieving process. They knew how to treat relatives experiencing bereavement with dignity and respect and followed this up by directing them to further emotional support if this was necessary. The chaplaincy service provided 24-hour support if required.

Compassionate care

- In our Intelligent Monitoring Report, March 2014, the trust was not rated as a 'risk' compared with other trusts in relation to compassionate care.
- The A&E Friends and Family Test is calculated using the proportion of patients who would strongly recommend the A&E department minus those who would not recommend it or who are indifferent. 100 is the highest score that can be awarded.
- Patients were asked to complete the Friends and Family Test before leaving.
- In May 2014, 37.5% of patients had responded, which is higher than the national average. The majority of those responding had stated they were extremely likely to recommend the department to their family and friends.
- All the patients we spoke with in A&E were complimentary of the care they had received.
- One patient who had used the A&E department on more than one occasion told us, "They're absolutely brilliant, no matter what time you come in."
- Another patient said the care was, "Great" and a third patient told us, "I wouldn't go anywhere else."
- We saw examples of caring and compassionate interactions with patients given in a quiet and dignified manner.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes were long waiting times in accident and emergency department and car parking cost and availability. The positive themes related to experiences the caring staff across all sites.

Patient understanding and involvement

- We heard and saw staff introducing themselves to patients.
- Patients told us they understood what had been said to them and had felt well informed about their care and treatment options.
- Patients who had been admitted to the hospitals from A&E departments across the trust and who had completed the inpatient survey in 2013 had scored 7.8 and 8.9 out of 10 respectively when asked if they had received enough information about their treatment and been treated with privacy and dignity.
- A TV screen in the waiting area provided information about waiting times.
- A large range of patient information leaflets were available.

Emotional support

- We spoke with staff about caring for relatives who had just lost their loved ones in A&E. We were informed family members were taken to the relatives' room in the emergency department.

Urgent and emergency services

- There was no designated area for relatives to view their loved one. The department's decontamination room was usually used for such purposes. A member of staff told us they hoped there would be a designated room when the A&E was reconfigured in the next three years.
- Bereavement packs were available in many languages and the department made a memory box for the parents of children who had died in the department that included a lock of their hair.
- Staff respected the large Asian community who used the hospital by ensuring deceased patients of the Muslim faith were pointed towards the east. In addition, staff were able to ensure a deceased patient could be released quickly to their families in accordance with their culture.
- We were informed relatives could stay as long as they wished in the department after a patient's death. Drinks were provided and patients were not moved until the relatives were ready.
- Relatives had the opportunity to visit the multi-faith chapel in the hospital. A member of the chaplaincy serving Christian and Muslim faiths was contactable at any time via the hospital switchboard.
- Staff contacted relatives of deceased patients six weeks after their death and sent them a small card. They checked on their welfare and directed them to further support if it was necessary.

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

Requires improvement

An electronic system was in place for tracking how long patients had been in the department to ensure they were admitted to wards or discharged home in a timely way. Generally the trust was meeting the 95% target for patients being treated within four hours in A&E however there were some occasions when they didn't meet this. There was a clear escalation policy in place when the department came under pressure.

The trust had identified the time patients were waiting in A&E to be handed over from the ambulance staff was a concern since June 2013. The issue of handover times was discussed subsequently throughout the year. Despite some improvements during the course of the year, in April 2014 it was noted that ambulance handovers remained a problem.

There was a clear escalation policy in place for when the department came under pressure. Key triggers resulted in specific actions, though it was acknowledged the success of these depended on the capacity and 'flow' to the rest of the hospital.

Patients informed us they felt treated as individuals and information was available to them about various illnesses and the complaints process if required. Staff had access to translation services through the use of a specialist telephone line.

Patients who walked into the A&E department were at risk from lack of privacy and dignity while giving confidential information to staff because of the reception arrangements. Limited support was available for vulnerable patients, for example those with a learning disability or mental health condition, but work had already begun to ensure patients living with dementia received a more responsive service.

Complaints and serious incidents, with any lessons learned from them, were discussed at monthly clinical governance meetings in the department. Information leaflets and posters about how to make a complaint were visible in the department.

Service planning and delivery to meet the needs of local people

- The A&E department served the population of Dewsbury and the surrounding areas. In the last financial year, the department had 85,399 attendances.
- The separate paediatric waiting area had ten chairs. A small number of toys were available, but because of the small space free play was limited.
- In April 2014, 329 patients had arrived by ambulance compared with 1240 in January 2014. Patients arriving by ambulance went straight into the clinical area for assessment. These meant patients were given privacy and dignity during this process.
- A triage nurse assessed all patients and directed them to the appropriate area of the emergency department.
- Walking patients were greeted by a receptionist, booked in and triaged as soon as possible. Children were

directed to the appropriate waiting area. Because patients had to raise their voices to speak with the receptionist, patients were at risk of being overheard while giving confidential information.

- The paediatric A&E saw approximately 50 to 60 patients a day. It was full at the time of our inspection and staff told us this was not unusual. Over the winter periods especially, it was often necessary to transfer older children to be treated in the adult area.

Access and flow

- During our inspection we saw the department was constantly busy, but staff were able to deal with the number of patients requiring care and treatment.
- A&E had a robust electronic system in place for tracking how long patients had been in the department to ensure they were admitted, transferred or discharged in a timely way.
- We looked at the data on the number of patients being treated within four hours of arrival in the previous 10 weeks. We saw the department had breached the 95% target 20 times in that period and in the middle of June for a period over five consecutive days. Weekends showed lower figures, for example 87.7% on 21 June and 82.4% on 22 June.
- In the NHS Confederation document Zero tolerance making ambulance handover a thing of the past (2012) it states ambulance handover and turnaround delays are not good for anybody least of all patients. National policy direction on this issue is clear long delays in handing patients over from the care of ambulance crews to that of emergency department (ED) staff are detrimental to clinical quality and patient experience.
- The trust had identified that the time patients were waiting in A&E to be handed over from the ambulance staff was a concern. On 5 June 2013, the trust's Clinical Executive Group (CEG) approved a Turnaround/ Handover National Target paper. The issue of handover times was discussed subsequently at CEG. Despite some improvements during the course of the year, on 23 April 2014 it was noted that ambulance handovers remained a problem.
- Trust-wide information showed that over a period of 3 months (April – June 2014) a total of 1745 patients had waited over 15 minutes to be handed over from the ambulance staff against a target of zero; 205 patients had waited more than 30 minutes and 5 patients had waited more than an hour to be handed over

Intermediate care teams generally worked between 9am and 6pm Monday to Friday, to aid safe discharge of elderly patients. An elderly assessment team was available seven days a week.

- Intermediate care teams generally worked between 9am and 6pm Monday to Friday, to aid safe discharge of elderly patients.
- Physiotherapists and occupational therapists assessed patients in A&E. They worked with the community matron to avoid admitting patients where it was safe to do so.
- In addition and when required, A&E received patients diverted from Pinderfields Hospital A&E department when Pinderfields Hospital was very busy. This occurred at night or on Sundays quite often and we were informed this affected staff morale. We were informed diverts from Dewsbury A&E rarely occurred.

Meeting people's individual needs

- Patients felt they were treated as individuals in their own right.
- Other than a leaflet for accessing the alcohol liaison service, we did not see any printed information for patients in any language other than English. A translation book on triage was available and the 'language line' telephone service was available when required.
- A&E staff knew about 'health passports' to aid their communication with people with a learning disability.
- There was no member of staff in the department who specialised in learning disabilities. We were informed staff had access to a specialist learning disability nurse if required, but had not required their assistance in the past 12 months.
- We spoke with members of staff about their ability to help patients living with dementia when they needed to go to the department. Dementia training was delivered once as part of the training for all levels of staff, although not all staff had received it. There were plans in place to address this.
- We spoke to the dementia champion for the department, who told us about the plans for A&E to become more dementia-friendly. They included using a quieter area of the department for people admitted with dementia and changing the colour of the curtains. This would reduce anxiety and stress.

Urgent and emergency services

- The woodwork around toilet doors had already been painted red to make them more obvious to patients with dementia.
- The department did not have a place of safety for patients attending A&E with a mental health illness. Patients waiting for input by the crisis team would be placed in view of staff.
- All staff had been trained in de-escalation techniques and dealing with violence and aggression. Staff informed us if they felt unsafe a member of the security staff would be called to the department.
- The department had access to a bariatric wheelchair and trolley when required.

Learning from complaints and concerns

- Information leaflets and posters about how to make a complaint were visible. We were provided with a complaint summary at trust-wide level from December 2013 to May 2014.
- Response rates varied from meeting the targets between 21% in one month to 100% in four other months.
- Number of complaints ranged from 17 in January 2014 to seven in April 2014. Clinical treatment accounted for the most complaints. The emergency department's newsletter stated the common theme for complaints was staff attitude and asked staff to be mindful of that.
- Complaints and serious incidents, with any lessons learned from them, were discussed at monthly clinical governance meetings in the department.

Are urgent and emergency services well-led?

Good

Staff were proud of the work they did. We saw a good rapport existed between all levels of staff during our visit and there was strong leadership from the lead nurse. Governance processes were evidenced at both local and trust level.

Staff informed us there was an open culture, with the sharing of complaints and incidents. As a result, lessons were learned and practices changed as a result. This was fed back to staff. The trust had a whistleblowing policy in place.

Vision and strategy for this service

- Staff knew the trust visions and values, but could not name them all. These were 'Caring Respect, High Standards, and Improving.'
- The lead nurse for the A&E department was proud of the work their staff undertook and enthusiastic about the reconfiguration plans for the department due to be in place by 2017.

Governance, risk management and quality measurement

- We asked staff if or how they would raise issues about safety concerns or poor practice in their department. Staff told us they felt confident taking any concerns to their line manager and knew they would be dealt with promptly.
- There were structured trust-wide emergency department governance meetings in place. In addition, clinical governance meetings for A&E at Dewsbury Hospital were held every two months. We saw the minutes for June 2014. Items included appreciations and complaints, number of clinical incidents reported and a discussion on an induction guide for locum doctors. Details on clinical incidents were not included in the minutes.
- We saw there were two risks clearly identified on the risk register for A&E within the medicine division. Appropriate actions had been taken to mitigate the risks. One person in the department was responsible for all root cause analysis of incidents.
- Any department breaches were investigated locally on a daily basis, but they had also been subjected to an external review. The service leadership had not felt this had been sufficiently thorough, and had thus undertaken their own more stringent review.

Leadership of service

- A good rapport existed between all levels of staff. We were able to see this during our visit.
- The lead nurse informed us they had developed a good relationship with the matron for emergency medicine across the trust and the lead clinician for all A&E departments. They worked together and met/spoke with the matron on a regular basis.
- We spoke with a range of staff in the department. They were knowledgeable about the services they delivered and proud to work in the department.
- The clinical lead for the entire emergency department across all sites was very knowledgeable and understood

the challenges and how they planned to deal with them. They were undertaking an internal management programme. Staff informed us the clinical lead had an open door policy and they felt confident in their leadership.

Culture within the service

- The friends and family test as well as listening to patient experience was seen as a priority and an indicator of quality care.
- Staff informed us there was an open culture, with the sharing of complaints and incidents.
- Discussions were held on lessons learned from them and practices changed where appropriate.

Public and staff engagement

- The trust had a whistleblowing policy in place that staff were aware of.
- Staff had engaged with the planned reconfiguration of the A&E services across the trust and the impact it would have on them. Plans had been put forward for nursing and medical staff to work across all A&E departments and to rotate between them, giving them opportunities for development and different experiences.

Innovation, improvement and sustainability

- The lead nurse had been involved in planning and reconfiguring of the new A&E department that was due to be completed in 2017. They thought the service improvement would make a positive impact on patients attending the department.
- Plans were in place for up to five advanced nurse practitioners to be added to the middle-grade doctor rota once additional training has been completed. The trust was recruiting four overseas doctors on secondment for middle-grade posts.
- For the proposed expansion of consultants, the board was aware in order to make the posts attractive concessions to flexible working would need to be accepted in order to fill the posts.

Medical care (including older people's care)

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

Information about the service

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

Summary of findings

We rated medicine as inadequate for safety. Improvements were required for effectiveness, being responsive and well-led. We found caring to be good.

We found the medical wards were clean and well maintained with arrangements in place for the prevention and control of infection. Staff were reporting incidents, which was encouraged by the trust. There were mechanisms in place to manage and monitor incidents. However, the medicine division was performing worse than the average for pressure sores and catheter-acquired infections. Staff shortages meant that the staffing levels and skill mix was not meeting national and best practice guidance, which impacted negatively on the care experienced by patients. The trust was using a significant number of temporary staff, including agency and locum medical staff. The appropriate arrangements were not always in place for dealing with medication. Not all staff were fully up to date with their mandatory training.

Treatment was in accordance with best practice and national guidance. Access to diagnostic services was provided seven days a week, although some patients had to wait over a weekend to access some tests and scans. Generally, patient feedback was positive about care received. Interpreting services were available, but there was little patient information available in different languages.

Medical care (including older people's care)

Clinical audits took place to ensure that staff were working to expected standards and following guidelines, although some areas needed improvements Access to diagnostic services was provided seven days a week, although some patients had to wait over a weekend to access some tests and scans.

Interpreting services were available, but there was little patient information available in different languages.

The medical division had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. Patient and staff engagement was improving. We had concerns that although the medical division was aware of many of the risks we identified, insufficient action had been taken to adequately address them.

Are medical care services safe?

Inadequate

There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards, such as specific patient harms. We were concerned over the number of grade 3 and 4 pressure ulcers; these had exceeded the number expected. We found the medical wards were clean and well maintained. There was sufficient equipment to meet people's treatment and moving and handling needs.

Record keeping on the medical wards varied in standard. Some records were completed well and reflected patients' needs, wishes and interactions. However, some were not completed fully, including fluid monitoring charts, which could mean that a deteriorating patient was not recognised in a timely manner.

Staffing levels regularly fell below the required numbers to meet patients' needs or they had shifts without the full range of staff skills needed. The trust used a significant number of temporary staff including agency, bank nurses and locum medical staff. The content of nursing handovers was good but on ward 5 we observed that staff did not receive information about all the patients on the ward, only the bay they were mostly working in. Staff may have, at times, been caring for patients in other bays of whom they had little or no knowledge.

Mandatory training was variable across the division, with some wards having poor staff training attendance rates. This meant that staff were not always up to date with current guidance, practice and procedures.

Medicines management required improvement in a number of areas. These included storage and disposal of patients' own controlled drugs, drugs being signed for before administration, and a lack of support and advice from pharmacists on some wards because of staff shortages.

Although the division was aware of many of the risks that we identified, we did not feel that these had been adequately addressed at the time of our inspection.

Medical care (including older people's care)

Incidents

- There had been nine serious incidents reported trust-wide for medical areas between April 2013 and May 2014. There were systems in place to report incidents. Incidents were reported using an electronic Datix system.
- Staff were made aware of the learning from incidents through a regular patient safety bulletin that was emailed to all staff. Staff were able to tell us about learning from these bulletins.Other systems were in place to feedback learning from incidents. These included electronic feedback to staff who had reported incidents and safety briefings at nursing handover.
- Regular mortality and morbidity meetings were held.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer information was clearly displayed at the entrance to each ward. This included information about the last time a patient had a fall on the ward, had developed a grade 3 or 4 pressure ulcer, had developed venous thromboembolism and urinary infections in patients with catheters.
- The trust was performing worse than the England average for pressure sores and catheter-acquired infections, according to nationally collated data.
- In March 2014 at the patient safety dashboard meeting, it was reported that the trust had exceeded the monthly and annual trajectory for category 3 and 4 pressure ulcers. They had reported 78 cases against an agreed maximum threshold of 18 cases.
- CCU was the only ward to be rated green from January to June 2014. Wards 2 and 5 had the fewest harm-free care days, with ward 5 being rated red or amber from January to June 2014.
- Risk assessments for falls were taking place on patients and the trust was undertaking work to try to reduce the incidence of avoidable falls.

Cleanliness, infection control and hygiene

- We found the medical wards were clean and well maintained.
- From May 2013 to 31 May 2014, the trust performed slightly worse than the England average for Methicillin-resistant Staphylococcus Aureus (MRSA) infections, but better for both Clostridium difficile (C.difficile) and Methicillin-sensitive Staphylococcus Aureus (MSSA) infection rates.
- All of the wards displayed information about how long they had been free of MRSA or C. difficile infections. These timescales varied from a few days to months. There was personal protective equipment and alcohol hand gels were available at the entrance to the wards and throughout the wards. Staff were observed using personal protective equipment and hand gels when they entered and left patient areas.
- There were policies and procedures in place to ensure that any patients carrying an infection were managed appropriately, including barrier nursing procedures where applicable. We saw that some patients on the wards were being barrier nursed (barrier nursing is used to ensure that cross infection is eliminated by use of protective equipment such as gloves, aprons and isolation procedures).
- Staff were regularly audited to make sure that they were following the correct hand hygiene techniques. Any staff members identified as not using the correct techniques were given information about where their technique was lacking and retested. We saw evidence of these audits.

Environment and equipment

- When we carried out observations on the wards, we found that there was enough equipment to safely meet people's needs. For example, there were sufficient hoists and slings and walking frames to make sure that people were supported to move in the most appropriate and safe way.
- There was enough equipment for staff to undertake observations and tests on the wards we visited.
- There was resuscitation equipment available on the wards. On ward 4 the resuscitation trolley was in a locked treatment room and had oxygen cylinders in front of it, which may have delayed timely access to this equipment.

Medicines

- The pharmacy department was unable to deliver what it believed was an adequate clinical pharmacy service to all wards because of severe staff shortages. Current staff levels only permitted 60–70% of the clinical pharmacist presence on wards that the pharmacy aimed to provide. Available resources were allocated to ensure that highest risk wards were covered. However, some staff on long-term absence were now returning to work and three junior pharmacists had recently been appointed.

Medical care (including older people's care)

- A successful initiative was the introduction of a dedicated team to facilitate patient discharge on seven wards. However, according to the trust's figures, only just over half of discharge prescriptions were reviewed by a pharmacist, across the whole trust.
- Action had been taken in response to a never event involving medicines at Pinderfields Hospital.
- The trust had conducted audits on medicine reconciliation, which is the process to ensure that any changes to prescribing when a patient enters hospital are intended by the doctor. The number of patients whose medicines were reconciled within 24 hours of admission had fallen by about 10% since January 2014. In June 2014, 55% of patients had their medicines reconciled in the first 48 hours after admission. (The number of patients included in the trust's June audit was small, 67).
- An extensive audit of prescriptions was conducted by the trust in October 2013. The audit found that nurses mostly recorded the administration of medicines. During our inspection we reviewed 26 prescription charts and found unexplained gaps in administration records in four of them. This confirmed the trust's previous findings.
- We observed a medicine administration round on one ward where we noted that on at least two occasions medicines were signed for by the nurse before the patient had been observed to take them, contrary to Nursing and Midwifery Council guidance. The effectiveness of treatment may have been compromised and records might have been inaccurate as to the timing of the medication or whether it had actually been taken.
- Medication records showed that the majority of drugs were given to patients in accordance with instructions and charts were signed appropriately. However, a number of errors were noted. For example, the weight of a patient had not been recorded but they were receiving a drug for which the dosage was weight-sensitive. A medicine, Madopar, that was time-critical and due at 8am was given at 10.35am. The nurse was not aware of 'time-critical medicines' or which medicines needed to be given first.
- In the discharge lounge we had concerns about unsafe management of controlled drugs because, on occasion, only one nurse was signing for the drugs and we found errors in the medicines being given to two patients to take home with them. Some patients waiting in the lounge were unable to take their routine medication at the prescribed time because the medicines were not available.
- Medicines, including controlled drugs, were not always correctly stored or disposed of in accordance with trust policy, national guidance and legislation. This meant that medicines may not be of the quality intended when administered, and that people who used the service were put at risk of receiving unsafe or ineffective medicine. On ward 4 we found controlled drugs that had not been disposed of promptly, resulting in large quantities of these drugs being inappropriately stored.
- We found that when medication errors took place staff were directed to further training, generally an eLearning course. There was not always competency testing following this to ensure that the member of staff had made changes to their practice.
- There were junior doctors routinely present on the wards most days to prescribe medications when required. At other times the wards were covered by the on-call medical rota. Staff were able to access medication as needed.
- New medication needed out of hours was accessed via the doctors on-call.

Records

- The standard of record keeping on the wards varied. We reviewed 20 patient records on a number of wards. Most records demonstrated that risk assessments had been carried out and acted on and those observations had been recorded and acted on.
- The trust had carried out clinical audits of records, identified some areas for improvement and was working with staff to implement improvements. We saw evidence on one ward of an audit for fluid balance charts which indicated that many of the charts had not been completed or the totals added up. Some patients' care and treatment needs might not have been identified or met in a timely manner.
- Some records were in an electronic format and accessible on computers, tablets and mobile phones. The majority of staff were able to access and contribute to these records.
- We were told agency staff could not input patient observations onto the electronic system.
- We observed on one ward that a doctor had left a computer screen with patient information clearly visible.

- The healthcare records management policy did not refer to the most up-to-date best practice guidelines from the Nursing and Midwifery Council published in 2009, although this was available via a hyperlink; it referenced 2005 guidance for records and record keeping.
- Staff on the discharge lounge did not always have access to information about the patients in the lounge. We were told that patient notes were kept on the ward with the drug charts until the discharge letter was done.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- There was documentary evidence that patients were consented for treatments appropriately. We observed staff asking people for verbal consent before assisting them.
- The failure of staff with the medicine division to have a full understanding and awareness of the Mental Capacity Act 2005, and how to use the nursing assessment tool to assess capacity, was recorded on the risk register. The trust were in the process of recruiting a part-time trainer for Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- The trust told us that Mental Capacity Act 2005 training was being delivered in a number of ways at different levels. There was some basic awareness training on induction, which 1456 staff had attended in 2013/14. It was also briefly covered in safeguarding adults training, which 1169 clinical staff had attended in 2013/14. There was also a full day of Mental Capacity Act training, which 58 clinical staff had attended in 2014/15, and bespoke training for groups of staff, which 45 clinical staff had attended in 2013/14.

Safeguarding

- Staff were aware that there was a safeguarding policy and the action they should take if they had any safeguarding concerns.
- According to records in July 2014, staff attendance at vulnerable adult's level 1 and children level 1 safeguarding training was 100% in the medical division. For level 2 within the medical division, it was 72% for adults and 68% for children safeguarding training. However, attendance from some wards, specifically acute medicine, at level 2 was as low as 49%.

Mandatory training

- Overall for the division of medicine the completion of core mandatory training was 73.6% (1200 staff out of a possible 1630) in June 2014.
- Information provided to us by the trust showed that core mandatory training for medical staff was at 91% against a target of 95% completed for the medicine division in June 2014.
- For the division of medicine fire training was 75% against a target of 95% and role-specific training was 72% against a target of 80%.
- The rate of attendance for various specialties and courses within the medical division varied between 49% and 100% according to June 2014 figures. This was reflected in some ward-specific data we were able to obtain at the time of the inspection. For example, on ward 4 all staff were up to date with safeguarding training and 30 of 36 staff were up to date with medicines management level 2 training. Ward 5 had lower completion rates; for example, 27 of 41 staff had not completed moving and handling training, 13 had not completed fire training and 17 had not completed safeguarding adult's level 2 training.
- 100% of staff had received moving and handling theory training. However, only 59% of staff on acute medicine, 70% of staff on cardiology and respiratory and 65% on elderly care wards were up to date with their practical moving and handling training. This meant that patients were not always supported by staff who had received an update in accordance with the trust's policy.
- Trust data showed that approximately 82% of staff had received resuscitation training; however, this varied greatly between medical areas, with the lowest area being acute medicine at 55% for those staff requiring the training every year. According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates.
- Medicines management training was also variable, with 65% (544/832 staff) receiving theory training at level 2. Only 51% of staff in the care of the elderly wards had completed this training, 58% in acute medicine and 60% in cardiology and respiratory wards. Staff told us that their competency to administer medications was not routinely checked or recorded unless incidents were

identified. We observed a number of incidents where best practice administration was not followed by staff. This meant patients were at the risk of not receiving medication or the correct medication.

Assessing and responding to patient risk

- The trust used the National Early Warning Score to monitor if a patient was deteriorating.
- The trust had recently introduced an electronic observation recording tool (Vital pac) at Dewsbury Hospital. This allowed staff to improve the monitoring of whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating.
- The trust had introduced hourly roundings on wards, where staff routinely checked on patients every hour. This meant that staff could assist patients and also identify any changes in their conditions. We saw the hourly roundings recorded in some patients' notes.
- When patients were identified as deteriorating, staff told us they were aware of what action to take. They told us that they were able to access medical support 24 hours a day either from medical staff on the ward or from doctor's on-call. They said there were not usually any problems accessing support if patients were deteriorating.

Nursing staffing

- The trust had calculated staffing levels for wards in November 2013 using the Safer Nursing Care Toolkit and these were to be reviewed and reported to the Board in July 2014.
- A new software tool has been purchased that measures the acuity and dependency of patients and patient flows to help plan safe staffing levels on the wards. We noted this would be rolled out from August 2014.
- The planned and actual staffing levels were displayed on a noticeboard in the corridor on each ward. On the days we inspected the wards; almost all staffing levels were lower than the planned staffing levels. We saw from rotas and Board reports, and staff told us, that this occurred often.
- We saw only one ward in the division had its established staffing level in the month May 2014.
- Ward 4 is a 28 bedded elderly care ward. We saw on 18 July 2014 the actual numbers of qualified nursing staff (RN) was lower than the planned number. This meant the ward did not meet the staffing ratio of one nurse to eight patients through the day. We found the number of RNs through the day was one less than the planned numbers. On the same night we saw the number of RNs was one less than the planned number. This meant the one nurse to 12 patient's ratio was not maintained. In addition, on the same night there was one less Healthcare Assistant (HCA) below the planned numbers of staff.
- SSU is a 28 bedded short stay unit. We saw on 7 and 14-20 July 2014 the actual numbers of RNs was lower than was the planned number. This meant the ward did not meet the staffing ratio of one nurse to eight patients through the day. We found the number of RNs through the day was one or two less than the planned numbers. In addition in the same time period, we saw the number of HCAs was less than the planned number of four staff through the day. On the 7 July 2014 there was only one HCA instead of the four. On the remaining days, there no more than three HCAs. On the 16-18 July 2014 night shifts, there were only two HCAs instead of three.
- The medical admissions unit (MAU) is a 28 bedded ward. On the 16 and 18 July 2014 we saw the number of RNs was one or two less than the planned number of staff. In addition on the 16 July there was one HCA less than the planned staffing numbers.
- Ward 8 is a 25 bedded medical ward. We saw on the 17 July there was one less RN than was planned this meant the ward did not meet the staffing ratio of one nurse to eight patients through the day.
- Wards varied in the number of nursing and healthcare assistant vacancies they had, the highest in May 2014 being CCU, which had 33% (6.7 whole-time equivalent [WTE]) vacancies, ward 5, which had 31% (9.5 WTE) and MAU 20% (8 WTE). In June 2014 the vacancy rate had improved: for CCU it was 5.5 WTE posts, ward 5 it was 7.6 WTE posts (six of which were registered nurse posts) and MAU it was 6.5 WTE (of which 6.3 WTE were registered nurse posts).
- There were no medical wards at Dewsbury Hospital that had their established staffing levels for the months of May and June 2014. However, some wards had much lower levels of vacancies; for example, ward 2 had a 6% vacancy rate in May 2014, which was less than two full time posts, and in June there was less than one full time post vacant. Some of the vacancies would have been accounted for by natural turnover of staff.

Medical care (including older people's care)

- Staff told us that although staffing establishments were improved with bank and agency staff, there were sometimes problems with the skill mix of staff who could not always perform all of the tasks required of them, such as taking blood and inserting cannulas.
- Staffing was reviewed at the daily operational bed meetings and a situation, background, assessment, recommendation tool used to raise any concerns.
- Board reports indicated that all ward managers had full supernumerary status. During our inspection we observed that most were working clinically for part of each week because of staff shortages.
- The trust was actively recruiting to the vacancies. We were told that 30 nurses had recently been appointed from overseas. We saw some of these nurses working on the wards in a supernumerary capacity until their induction was complete. The trust was also recruiting newly qualified nurses, some of whom would start in September 2014. Recruitment was ongoing.
- Nursing shortages was also experienced across specialist nurse services. The Cancer Peer Review 2012/13 had raised a serious concern over the workload of the clinical nurse specialist, working across all three hospital sites. An urgent business case was due by the end of July 2014 to recommend actions needed to address this.

Medical staffing

- There were a number of medical staff vacancies at all grades, including middle and consultant level. The trust was using locum medical staff to cover vacancies.
- The trust operated the 'physician of the week', which meant there was continuity of care as patients saw the same doctor.
- Medical staffing on the MAU included two consultants. Between 9am and 9pm there was one foundation year 1 (FY1) grade doctor, two senior house officers and one specialist registrar. The FY1 doctor covered the wards from 5pm.
- Overnight, 9pm to 9.30am, there was a FY1 doctor who covered the wards, two senior house officers in MAU and one specialist registrar.
- Consultant ward rounds on weekends ensured patients could be discharged from MAU and SSU.
- There was a consultant thrombolysis rota of one in five weeks for the trust and we were told the trust was recruiting to a sixth post.
- Junior doctors told us there was a need for more doctors to be available out of hours and at weekends.This was corroborated by evidence from the Medical Deanery. There was a standard escalation process in place and junior doctors had been made aware to contact a consultant if the registrar was not available.
- There were 24 consultants on the rota for weekend cover, therefore each consultant worked approximately once every 24 weeks.
- The medical senior leadership informed us that each of the medical specialities were developing their own weekend cover, to start in Autumn 2014, which would include a review of all new admissions, effective management of any patients who deteriorated and discharge of those patients able to go home on a Saturday or Sunday.
- Within acute medicine, there was a budget for 11 WTE consultant posts. There were four substantive posts filled at Pinderfields Hospital and three at Dewsbury Hospital. The four vacancies were covered by locums.
- We were told that the trust mainly used one locum agency, which helped ensure quality and fill rate for the rotas.
- Junior doctors told us that senior medical staff were contactable by phone out of hours if they needed any support.
- We attended a medical staff handover meeting. The doctors prioritised and discussed in the handover the very sick patients and those with high National Early Warning Scores, which included plans of treatment and care. They also discussed any patients with outstanding investigations and patients who had recently been admitted and still had to be clerked by a doctor. There was a handover template used and they used a situation, background, assessment, recommendation tool. There had been an audit of handovers that suggested evening handover was satisfactory but morning handover required improvement. On some wards there was a multidisciplinary handover each morning, which staff said had improved discharges.
- On ward 4 there were two permanent consultants; one for stroke and one for neurology patients, together with a team of more junior doctors.
- Some concerns were raised by junior doctors about the medical cover on ward 4. Comments included, "Medical staffing is bad on ward 4, there is often only one doctor and they regularly finish late", "It feels stretched at the

top, but not unsafe", "The minimum junior staffing should be two. This week we only had one junior doctor for three days and two for two days. Last week there was only one doctor every day", "Junior doctors often work till 7pm" and "We are very stretched medically, but this is not really recognised by the rest of hospital due to the ward's rehabilitation status, therefore it is not staffed accordingly".

Major incident awareness and training

- The trust had plans in place to manage unexpected or unprecedented events that would enable services to continue to be delivered. This included a Resourcing Escalatory Action Plan, which we saw in operation during the unannounced visit because of bed capacity issues.
- The trust was developing a number of initiatives to manage winter pressures. This included introducing an acute ambulatory care model from September 2014 based on pilot work to date. A review of schemes to manage winter pressures had been completed and business cases put forward for 2014/15.

Are medical care services effective?

Requires improvement

Staff worked in line with National Institute for Health and Care Excellence (NICE) guidelines. Clinical audits took place to ensure that staff were working to expected standards and following guidelines. There were a number of national audits that required additional focus to ensure patient outcomes were at the national average or above.

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

Competency checks for nursing staff were not robust. Nurses did not have competency checks for administering medication. Staff commented that they were sometimes moved from their own specialism to an area they were less competent in and that agency staff did not always have the competencies for the speciality they were working within.

There was evidence of good multidisciplinary working on wards and on the whole patients we spoke with were happy with their access to pain relief. However, the Cancer Patient Experience Survey indicated that hospital staff did not always do everything to help control pain all of the time.

Evidence-based care and treatment

- Staff worked in line with NICE guidelines.
- The Commissioning for Quality and Innovation (CQUIN) framework aims to secure better outcomes for patients and improvements in quality and innovation above the baseline mandated in the NHS National Contract. The trust achieved 89% of the CQUIN goals in 2013/14.
- There was a trust-wide annual audit priority programme for 2014/15 that included 28 audits for the division of medicine. Examples of audits included chronic heart failure management, national diabetes foot care and falls and fragility fractures.
- The trust's elderly care strategy focused on implementing and standardising practice in accordance with the national 'Quality care for older people with urgent and emergency care needs' (the Silver Book). This was monitored by the 'Elderly care task force'.
- In March 2014 the trust launched the 'Forget Me Not' scheme and was recruiting volunteers to aid implementation. This would also be monitored through the CQUIN goals.
- Analysis of data showed that the screening for patients living with dementia, over 75 years was red rated quarter (Q) 4 in 2012/13, Q1, Q2, Q 3 and Q4 in 2013/14. The percentage of over 75 years who were referred to a specialist was also red in all these quarters.

Pain relief

- Patients were able to request pain relief and there were systems in place to make sure that additional pain relief could be accessed via medical staff if required.
- Patients we spoke with had no concerns about how their pain was controlled.
- Pain assessments were carried out with some patients, but this was not recorded consistently across the medical division.
- Feedback from patients as part of the Cancer Patient Experience Survey 2012/13 indicated that pain control was not always well managed. The trust was in the bottom 20% nationally for this outcome.

Medical care (including older people's care)

Nutrition and hydration

- Patients were able to access suitable nutrition and hydration, including special diets during meal times and when these had been pre-planned.
- Patients reported that on the whole they were satisfied with the quality and quantity of food.
- We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking.
- We reviewed approximately five fluid balance charts; all contained entries and most were fully completed.
- The Malnutrition Universal Screening Tool was in use within the trust to better identify patients at risk of malnutrition and dehydration and we saw evidence of this mostly being completed in the notes we reviewed. The results of the Cancer Peer Review 2012/13 raised serious concerns over the unacceptable waiting time for dietetic support for patients with upper gastro-intestinal cancer.

Patient outcomes

- There were no Tier 1 mortality indicators for the trust, which meant that there was no evidence of risk for the composite indicator for in-hospital mortality and Dr. Foster composite of hospital standardised mortality ratio indicators or the summary hospital-level mortality indicator.
- Clinical audits took place to ensure that staff were working to expected standards and following guidelines. The draft quality account for 2013/14 indicated that the trust participated in 91% of the national clinical audits and 100% of the confidential enquiries it was eligible to participate in. A further 213 local audits were completed in 2013/14. Examples of learning were included in the quality account and had been disseminated to the divisions.
- Dewsbury Hospital was performing worse than the England average in the heart failure audit for all elements of in-hospital care, including input from specialists and receiving a specialist test called an echocardiogram. The hospital was performing better than the England average in measures assessed relating to discharge. These included receiving discharge planning, referral to a specialist service and receiving the appropriate medication.
- Dewsbury Hospital was performing worse than the England average for the Myocardial Ischemia (heart attack) National Audit Project indicators. The hospital was performing at 82% compared with 94% nationally for the proportion of patients with a discharge diagnosis of nSTEMI (non-ST segment elevation myocardial infarction) who were seen by a cardiologist or member of their team. The hospital was performing worse (39% compared with 53% nationally) for the proportion of patients with a discharge diagnosis of nSTEMI who were admitted to a cardiac unit or ward and the proportion of patients (55% compared with 73% nationally) with a discharge diagnosis of nSTEMI who were referred for or had angiography.
- The National Diabetes Inpatient Audit indicated that Dewsbury was worse than the England average in 13 of 22 indicators and better than the average in seven of the indicators.
- The Annual Stroke Peer Review (18 March 2014) found services at the trust had improved but concerns were raised over staffing levels, especially the stroke trained nurses and therapists. Speech and language therapy appeared reduced and there was an absence of psychological support.
- Staff were able to access local policies using the intranet and staff permanently allocated to wards were aware of specific policies that affected the work carried out on their ward.
- The risk of patients being readmitted to the trust was higher than the England average in elective gastroenterology and non-elective respiratory medicine, but site-specific data was not available. Commissioners' had received negative feedback from patients waiting for gastroenterology services at the trust.

Competent staff

- Ward managers were working towards making sure that nursing staff had the appropriate number of supervision sessions each year, and received an annual appraisal. According to performance information, there was still some work to do to achieve this. A number of staff commented that their supervision sessions had been cancelled because of work pressures.
- 53% of non-medical staff had an annual appraisal recorded against the target of 80% for the rolling 12-month period up to and including June 2014. The trust commented that this was because of an increase in pressure on frontline staff in recent months. The

trust-wide medical division annual appraisal rate for June 2014 was 87% for consultants and 90% for non-consultants with a target of 90%. There was no division/ward-specific information available.

- Junior doctors received support, appraisal assessment and guidance to ensure they were competent to carry out their role. Doctors commented about how supportive consultants were. However, some told us they did not always receive local training, for a number of reasons including being too busy with ward duties to attend.
- Doctors were subject to the revalidation process.
- The trust had developed a competency - based work book for all band 2 and 5 staff to complete. On the wards we visited this had not been fully implemented, had been very recently started or, as on ward 4, not yet started.
- There were no routine competency checks in place for nurses who administered medication.
- were familiar with the wards were used whenever possible. However, concerns were raised by a number of staff about the competency of bank and agency staff filling shifts at short notice. Internally staff commented that they were frequently moved from their own specialism to an area which they were less competent in and that agency staff did not always have the competencies for the speciality they were working within. We observed this in practice, for example intensive care nurses were moved to the care of the elderly wards and agency staff were not competent in inputting data into the electronic patient observation recording system.
- We were told by staff that there was limited induction for agency staff. The permanent staff gave the agency staff member a tour of the ward highlighting the key points, for example where the resuscitation trolley was.

Multidisciplinary working

- There was clear evidence of multidisciplinary working on the wards. There was regular input from physiotherapists, occupational therapists, dieticians and other allied health professionals when required. National guidelines for therapy time, 45 minutes of therapy a day were not being met. Staff acknowledged that in some circumstances patients did not need the therapy or were not medically well enough to have it.
- There was evidence that the trust worked with external agencies such as the local authority when planning discharges for patients.
- Transfers between sites were usually well managed and for clinical reasons, for example patients requiring rehabilitation following a stroke were often transferred to Pontefract or Dewsbury Hospitals. Patients from CCU at Dewsbury were transferred to Pinderfields or Leeds if specific tests were required.
- There was an elderly in-reach multidisciplinary team and care record that facilitated discharges. The team worked Monday to Friday.
- There were no psychology services for stroke patients.

Seven-day services

- Access to diagnostic services was available seven days a week, for example, x-rays, MRI and CT scans.
- Access to support services such as therapy services varied across the weekend. There was no routine physiotherapist over the weekend. A small number of therapy assistants worked some weekends.
- There was an on-call pharmacist available out of hours. The inpatients pharmacy was open 9am to 5pm Monday to Friday. On Saturday it was open 9am to 12noon and on a Sunday from 10am to 12.30pm. At other times there was an on-call rota for pharmacists.
- Consultant presence out of hours varied across the medical wards. On most wards the consultant cover over a weekend was on-call only. Consultant ward rounds on weekends ensured discharges from MAU and SSU. There was a consultant on-call for thrombolysis if required.

Are medical care services caring?

Good

Overall, patients we spoke with were content with the level of care they received from staff, although a number commented that staff did the best they could despite how busy they were and the pressure they were under. Patients raised no concerns about their privacy and dignity being compromised and on the whole staff were thought polite, patient and caring. One relative raised concerns about staff

not being aware of a patient's social circumstances and the effect an admission could have: the patient was a carer of their spouse who had dementia and the spouse had been sent home to an empty house in a taxi.

Most patients were not actively involved in discussions about their treatment, but they did not feel that this was a concern. Some patients had been very involved in discussions about their future treatment needs. Patients were able to access support services, such as mental health and end of life practitioners.

The response rate and score for the inpatient survey friends and family test for June on the medical wards at Dewsbury Hospital was very variable. The lowest response rate was on the SSU (only 14.3% of patients) and the highest response rate was on CCU (57%). In terms of ratings the wards scored from 57 (ward 6) to 85 (ward 5).

Compassionate care

- From analysis of the CQC Intelligent Monitoring Report there was no evidence of risk regarding compassionate care, meeting physical needs, patient overall experience, treatment with dignity and respect and trusting relationships.
- The 2013 CQC adult inpatient survey showed that the trust was average when compared with other trusts in all the areas reviewed.
- The response rate and score for the inpatient survey friends and family test for June on the medical wards and Dewsbury Hospital was very variable. The lowest response rate was on the SSU (only 14.3% of patients) and the highest response rate was on CCU (57%). In terms of ratings the wards scored from 57 (ward 6) to 85 (ward 5).
- A majority of the 54 patients and relatives we spoke with were happy with the care and compassion they received on the ward. Comments included, "I've been in three days. You can have a laugh with the nurses. I've seen both a dietician and a diabetic specialist nurse. It's very clean – they are always cleaning", "I'm comfortable most of the time. I can use the call bell if I need assistance and staff come soon after I've pressed it" and "The food's not very palatable".
- Patients and relatives believed that staff cared for them very well despite the pressure they were under and how busy they were on the wards. For example, patients said, "Staff are frightened of losing their jobs" and "I feel sorry for the staff, they are so busy".
- Throughout the inspection we saw patients being treated with compassion and respect and their dignity was preserved.
- Call bells on the wards were mostly answered promptly and were in reach of patients that required them.
- Hourly roundings (checks to make sure patients were comfortable and had what they needed) had been introduced to make sure that staff were aware of any emerging needs patients had.
- Relatives were encouraged to be proactively involved in the care of patients and there were extensive visiting hours.
- Patient-led assessment of the care environment showed that the trust was higher than the England average for cleanliness, food and facilities, but slightly below the England average for privacy, dignity and wellbeing.
- The National Cancer Patient Experience Survey 2012/13 results for inpatient stays showed that the trust was average or above average when compared with other trusts in 14 out of the 17 areas reviewed. However, an analysis of complaint data across the medicine division from October 2013 to March 2014 found of the 241 formal complaints 18 related to staff attitude and behaviour.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes were car parking cost, the state of Dewsbury hospital and availability and concerns about care provided on elderly care wards. The positive themes related to the caring staff across all sites.

Patient understanding and involvement

- Patients on the whole felt that they were listened to by staff and most were aware of what was happening in their patient journey.
- Most patients had not been involved in formulating their care plans, but they were aware of what treatment they would be having and why. Some patients reported that medical staff had spent time with them, listened to them and discussed treatment options.

Emotional support

- Most patients and relatives reported that they felt able to talk to ward staff about any concerns they had, either about their care or in general.

Medical care (including older people's care)

- There was some information within the care plans to highlight whether people had emotional, mental health or memory problems.
- Patients were able to access clinical nurse specialists and specific teams for additional care and support, for example, teams for mental health, stroke end of life and dementia.
- There were rooms available where private discussions and sensitive conversations could take place with patients and/or relatives.

Are medical care services responsive?

Requires improvement

Dewsbury Hospital offered a variety of medical specialty services. The health needs of most patients were met and there was access to specific support services such as mental health services and therapy support.

The staffing establishment did not always reflect the acuity and dependency of patients, which might have affected patient care. For patients whose first language was not English, interpretation services were available, but most ward staff communicated using family and other staff within the hospital. There was no visual patient information available in different languages.

The trust had recognised that access and flow of patients through the hospital could be improved and plans had been proposed/were in place to do so. Medical patients, often 20 to 30 a day across the trust, were on surgical wards, which may have meant they were cared for by staff that were not trained in medical specialities. The trust was significantly higher (38%) than the England average (21%) for delayed transfer of care while waiting for further NHS non-acute care.

The majority of patients and relatives felt that they could raise concerns and were confident that they would be listened to.

Service planning and delivery to meet the needs of local people

- There were a number of different wards at Dewsbury Hospital, including general medicine, care of the elderly, cardiology, respiratory, gastroenterology, neurology and stroke care.
- Some wards were designated as specialist medical wards, but the vast majority of the patients were care of the elderly patients. There was a concern that the staffing establishment did not always reflect the acuity and dependency of patients; for example, elderly patients who were often frail with dementia-related problems and required additional support. This meant that there was the potential that staffing levels were on occasion too low.
- During busy times the hospitals REAP came into operation, which we saw during the unannounced visit because of bed capacity issues. The on-call manager had been on site all day and consultants had been called in because of REAP being escalated to level 3. There were 16 available beds reported with only eight of these being for acute medical admissions. Staff acknowledged after the inspectors raised concerns that this might not be sufficient to ensure enough capacity overnight. It was accepted that patients would be transferred to inappropriate ward areas or one of the other sites if required. There was a shortfall of nurse staffing for the night shifts and a plan was discussed to move staff between ward areas when required. Some bank shifts were unfilled and even with the sharing around of staff; some areas were still understaffed, which may have the potential to affect patient care.

Access and flow

- The data provided to us by the trust showed that occupancy levels overall were between 84% and 85.3%, which was lower than the national average. However, during our inspection the majority of the medical wards were full.
- Staff told us that most patient transfers to other hospital sites took place between the hours of 7am and 9pm, unless clinically indicated.
- Feedback from patients indicated they often moved beds during their stay in hospital for a number of clinical and non-clinical reasons. The majority of medical patients were admitted to MAU, where the planned length of stay was 24 hours or less. Following this, patients were either medically discharged or transferred to another ward for further treatment or rehabilitation.
- Medical staff told us there were often 20 to 30 medical patients (outliers) on the surgical wards across the trust. Data from 1 June to 11 July 2014 indicated that the number of medical outliers on any one day ranged from five to 35.

Medical care (including older people's care)

- We attended a bed management meeting at Pinderfields Hospital that included the daytime site manager, night site manager, two matrons and the senior manager on-call. It also included, via teleconference, the other hospital sites (Dewsbury and Pontefract) and the executive director who was on-call. The meeting was to try and ensure patient flow throughout the hospital and the Resourcing Escalatory Action Plan was discussed
- The trust was meeting referral to treatment times for general medicine (100%), gastroenterology (97.3%) and dermatology (100%), but not for gynaecology (87.2%) However, there had been several informal complaints regarding the lack of follow up appointments, especially for gastroenterology, cardiology, rheumatology over the last three to six months (Annual Report of the Patient Liaison Team, July 2013).
- The average length of stay for non-elective admissions in general medical patients was between five and six days, which was less than the England average of six to seven days.
- The trust's June 2014 performance report stated that it was meeting the targets for diagnostic waiting times of less than six weeks and the cancer 62 days wait from urgent GP referral to first treatment. However, it was not meeting the 18 week referral to treatment time. The national target was 92% and the trust's year to date performance was 89.8%.
- The trust was significantly higher (38%) than the England average (21%) for delayed transfer of care while waiting for further NHS non-acute care, but significantly better at completing assessments, 6% delayed compared with the England average of 19%.
- There was an early support discharge that facilitated discharges Monday to Friday and where possible planned discharges for the weekend. There were good discharge templates on the computer system, with separate sections for occupational therapy, physiotherapy and dieticians that enabled multidisciplinary discharge planning.

Meeting people's individual needs

- The trust had a dementia programme in place, a 'Forget me not' scheme with an accompanying action plan and was work in progress. Not all wards had implemented the scheme. We identified some patients living with dementia on MAU, where the scheme was not operational. A staff member told us patients were not on the ward long enough to implement the scheme. This might have put patients at risk of harm if their care needs were not formally recognised.
- The trust was working towards achieving a nationally agreed dementia care CQUIN (Commission for Quality Innovation – a payment reward scheme agreed by local commissioners aimed at encouraging innovation), for which it was required to ensure that patients were identified and assessed on admission with regards to dementia. The trust had significantly improved against the CQUIN target for identifying and assessing patients with dementia in 2013/14, although it was still below the national target of 90%. The Patient Experience Gap Analysis to Patient Feedback (April 2014) noted that the medicine division had to do," a great deal of work to achieve better patient experience" with regard to people living with dementia. The reports goes on to state, "Complaints relating to poor care of patients who suffer from dementia is a strong theme noted by families and carers in many letters received".
- As a result the trust introduced an interim dementia lead nurse, commenced dementia awareness training, introduced the 'Forget Me Not' scheme, developed three quality indicators for dementia as part of a CQUIN and began work on projects to improve five elderly care wards to make more dementia appropriate.
- A dementia screening team had recently been appointed to work across the hospital to ensure all acute admission patients aged over 75 were screened.
- There was a plan to improve ward environments for people with dementia; for example, large clocks with the date and time in each room were being fitted during the inspection.
- Dementia and 'Forget me not' training had commenced across all staff groups, including nurses, housekeepers, diagnostic services, board members, the chief executive and other senior managers.
- The trust had access to interpreters and a telephone interpreting service. People who did not have English as a first language may not always understand the care, treatment and support choices available to them because staff do not always use appropriate interpretation services. Staff often used family or other staff members as interpreters, which might have breached confidentiality in some instances.
- There were no visible leaflets and patient information available in different languages.

Medical care (including older people's care)

- The carers of people living with dementia and learning disabilities were encouraged to stay with the person to support the person and make sure that their hospital admission was the least disturbing as possible.
- The wards were able to request extra staff to support people who were displaying challenging behaviour, who were exploring their environment or who needed closer observation, but there were not always staff available to do this. Many staff commented that they were often supporting such people while still attending to their routine duties.

Learning from complaints and concerns

- A trust review of complaints from October 2013 to March 2014 identified that there had been across the medicine division 32 high graded complaints.
- There were 103 medium graded complaints across the medicine division and 106 low graded complaints, one example related to the backlog of test results.
- Therefore from October 2013 to March 2014 the medicine division had received 241 formal complaints. Analysis showed that the top three were with regard to clinical treatment (166), staff attitude and behaviour (18) and administration/transfer/discharge procedures (15). The category of clinical treatment covered a number of secondary subjects such as poor nursing, clinical care, the delay in treatment, coordination of treatment and falls.
- Changes were introduced in the trust to bring together information about the patients' experience into one integrated report, which was discussed at the 'Learning from patient and staff feedback group' From complaints, and other patient feedback such as surveys and the family and friends test, Patient Experience Improvement Plans were developed. This was a fairly new initiative and incorporated information from other sources such as NHS Choices, compliments, incidents, CQC mock inspections, divisional assurance visits and audit results.
- We found that formal complaints were analysed and reported to the Trust Board, but a great deal of information on quality and the patient experience was received as informal complaints, which were not reported to the Trust Board. This meant that although the information was being correlated, analysed and local action plans developed from these, the Trust Board was not necessarily sighted on the data to help inform decision making.
- Complaints were discussed at the division of medicine monthly governance meeting and there was a weekly tracker in place to improve management of complaints.
- The governance manager kept a log of all complaints. Matrons saw all the complaints. Each complaint was approved by the lead nurse for medicine and signed off by the chief executive.
- Staff told us they were informed about the learning from complaints and concerns. Information was disseminated to staff at daily safety briefings or by email. We saw evidence of this.
- Most of the patients we spoke with were not aware of the complaints procedure. The majority of patients and relatives felt that they could raise concerns and were confident that they would be listened to.
- The number of days since the last compliant was displayed at the entrance to each ward.

Are medical care services well-led?

Requires improvement

Leadership throughout the division had lacked stability and direction because of many staff changes. The senior divisional leadership had all been in post for less than a year and there had been many staff changes over the last year, across all grades. The senior leadership had a good understanding about their roles within the division and were aware of most areas of risk and developments required to improve patient care. A number of developments were being implemented, but it was too early to say whether they would be effective and sustainable.

However, during our inspection we raised concerns about Ward 4 at Dewsbury District Hospital. The trust subsequently submitted information detailing how they would address the issues raised. In addition, prior to the inspection, we had been told by the trust that ward 5 had reduced the number of beds because of significant gaps in staffing and concerns about patient safety. Following this, staff had been instructed by management to take two extra patients in response to demand for beds.

The division had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital.

Medical care (including older people's care)

Patient engagement was improving and there were a number of initiatives in place to further improve engagement with both patients and staff.

Although the division was aware of many of the risks that we identified, we did not feel that these had been sufficiently addressed at the time of our inspection.

Vision and strategy for this service

- The trust had a clear vision and strategy and this was displayed throughout the hospital.
- Staff on the wards were aware of this strategy and the changes to service provision the trust was planning.
- Most staff were aware of the changes that were to be implemented to improve patient flow and experience within acute medicine, such as the changes to the ward functions and number of beds on the Dewsbury site.

Governance, risk management and quality measurement

- Wards used and displayed quality information and the safety thermometer to measure their performance against key indicators.
- Where wards were consistently falling below the expected levels of performance, action plans were put in place to improve performance and maintain safety. For example the action to close some beds on ward 5 was related to an increase in patient harm being reported, complaints relating to patient care and low staffing levels. Prior to the inspection, we had been told by the trust that ward 5 had reduced the number of beds that were open to 16 because of significant gaps in staffing. Staff told us this had reassured them about being able to maintain patient safety, but they were concerned that despite this reduction they had then been told to take extra patients in response to demand for beds. During the inspection we found there were 17 patients on the ward and staff said there had been 18 at one point. Staff told us they were instructed to take the patients by management. Following our announced inspection the bed number reduced to 16 and, at the time of our unannounced inspection, staff confirmed this had been maintained.
- Wards used and displayed quality information and the safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action plans were put in place to improve performance. The timeliness of action following concerns being raised was not as responsive as it might have been.
- During our inspection we raised concerns about Ward 4 at Dewsbury District Hospital. These concerned the process of managing nursing documentation and the warm temperature of the clinic room and effect on medicines storage. The trust subsequently submitted information detailing how they would address the issues raised.
- There were regular, usually monthly, governance meetings for the division of medicine and the outcome of these was fed back to staff via email.
- There were risk registers at a number of levels within the trust, from board to division that on review identified many of the risks we had identified during our inspection, such as staffing levels. However, we were concerned that sufficient improvements had not been made despite the trust's awareness. We were also given two different versions of the register during the inspection, which may have led to confusion within the trust as to what the key risks and actions were.

Leadership of service

- Leadership throughout the division had lacked stability and direction because of many staff changes.
- The senior divisional leadership (clinical director, senior associate division of nursing and associate director of operations, which was an interim role) had all been in post for less than a year. They had a good understanding about their roles within the division and were aware of the risks and developments required to improve patient care.
- There was a workforce strategic plan for the medicine division.
- Staff and managers told us there had been many staff changes over the last year, across all grades, and this had not been good for developing confidence or accountability within the trust. However, most staff supported their new managers and felt that the recent changes would improve patient care and their work experience.
- Staff said that the executive team, especially the Chief Executive officer, at the trust was visible.

Medical care (including older people's care)

- There was a management structure in place in the wards we visited. Wards had a band 7 ward manager. Ward leaders had limited supernumerary time because of staff shortages.
- Matrons were in post within the division to oversee division operational issues and assist with arranging additional staff. Again, many of the matrons had been recently appointed to their roles. Some matrons covered more than one site. Staff said they felt some matrons were therefore not as accessible.

Culture within the service

- There was good team working on the wards between staff of different disciplines and grades.
- Observation during the inspection indicated a reactive culture on most wards because of the intensity of working under staff shortages.
- Service-level data was not available for specific wards but trust-wide results of the staff survey were poorer than the national average; 34% of staff said they were able to provide the care that patients needed and 40% of staff recommended the trust as a place to receive treatment.

Public and staff engagement

- The trust took part in the friends and family test. Results were displayed at the entrance to each ward.
- There was information in public areas about the Patient Advice and Liaison Service and how to make a complaint.
- The medicine division was using patient stories as a way of trying to improve the quality of care people received and raise awareness of the impact that poor care can have on patients. This was recorded within the governance meeting's minutes.
- The trust has been proactively encouraging and facilitating staff engagement. This has included listening events, which have been held since April 2013. Evaluation of the events indicated that staff were proud of the teams they worked in and the care they gave to patients. The most significant change cited for future developments was the successful recruitment and retention of staff for all clinical areas. Staff noted this was starting to happen and felt this would improve the poor staff morale.

Innovation, improvement and sustainability

- We saw examples of improvements the trust was making to ensure patients received appropriate care and treatment in a timely manner.
- The trust had introduced in Dewsbury Hospital electronic recording of patient observations. This helped to ensure that key observations were done in a timely manner and enabled both nursing and medical staff to see at a glance whether recordings had been delayed and whether the patient was improving or deteriorating. The system was also audited for effectiveness and we saw examples of this.
- The dementia screening team, which had been operating for three to four months, worked across the trust to ensure that all people aged over 75 with an acute admission to the hospital were assessed for dementia. This was recorded electronically and in patients' notes. The team was able to refer direct to memory services if required to ensure patients got the appropriate support.
- Pilot schemes run in 2013/14 to support winter pressures had been evaluated and proposals to fund these schemes were planned.

Surgery

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

Information about the service

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

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

We talked with 10 patients and 23 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified), medical staff (both senior and junior grades) and managers. We observed care and treatment and looked at care records for six people. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Summary of findings

We rated surgical services as good for caring, but improvements were required for safety, effectiveness and well led. We had serious concerns over the number of patients waiting to be admitted for treatment (the target for the referral to treatment at 18 weeks was not being met) at times the access and flow of patients on the wards and in theatres were ineffective and there were delays in sending discharge letters to GPs.

There were effective arrangements in place for reporting incidents and staff were encouraged to report them. Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Appropriate staffing levels and skill mix across all surgical services were not always sustained at all times of the day and night.

There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. However, the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completely embedded in theatres and daily checks of equipment were not consistently carried out. Staff awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were limited.

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and

Surgery

reviews to improve patient outcomes. Mortality indicators were within expected ranges. Other indicators showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, and the number of emergency admissions following elective admissions.

The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (CEPOD).

We observed positive, kind and care provided to patients and most patients felt they understood their care options and were given enough information about their condition.

Surgery had systems in place to plan and deliver services to meet the needs of local people. The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. We found that staff were responsive to people's individual needs, but that there were serious concerns over waiting times, such as the 18-week referral to treatment times, waiting for care once in hospital and the high number of medical outliers on surgical wards.

There was good ward leadership and staff felt supported and had seen positive changes in some areas to improve patient care. Some staff reported a 'disconnect' between middle management and themselves, and felt there was a lack of communication and flexibility to support autonomous working. There were changes in management structures and reconfiguration of services that had led to low staff morale, particularly in theatres.

Are surgery services safe?

Requires improvement

There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which were in line with national guidance. Staff were encouraged to report incidents and most received feedback on what had happened as a result.

Staffing establishments and skill mix were reviewed regularly. However, optimum staffing levels and skill mix across all surgical services were not always sustained at all times of the day and night. Effective handovers took place between shifts and included daily safety briefings to ensure continuity and safety of care.

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

There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. However, the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completely embedded in theatres and briefings before and after surgery were not consistently taking place.

There was little evidence to show effective use and staff knowledge of the principles of the Mental Capacity Act 2005 and the Deprivation of liberty safeguards.

There were arrangements in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment, although there were gaps in the daily checks for anaesthetic equipment. Care records were completed accurately and clearly.

Appropriate plans were in place to respond to emergencies and major incidents. Staff were aware of their roles and responsibilities in urgent and emergency situations.

Incidents

- Staff were aware of the process for investigating when things had gone wrong. We found staff were familiar with the process for reporting incidents, near misses

and accidents using the trust's electronic system, and were encouraged to report them. Most staff told us they received feedback regarding the incidents they had reported.

- There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. We saw serious incident investigations had been undertaken in two cases and one investigation was ongoing. Theatre staff were aware of the incidents relating to swabs, but some staff told us they had only recently been made aware of the retained instrument.
- A safer surgery group had been established to review the never events. This included changes to peri-operative documentation and the swab count policy. During our observations in theatre we observed correct verification procedures taking place to ensure swab counts were correct.
- There had been 11 serious incidents reported trust wide for surgical areas during 2013/14. The themes related to areas which included clinical care, management of the deteriorating patient and surgical error. A safer surgery action group had been developed to review all surgical processes and a root cause analysis investigation was being carried out. Root cause analysis is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again.
- Mortality and morbidity meetings were in place in all relevant specialities. All relevant staff participated in mortality case note reviews and reflective practice.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. Safety thermometer information was clearly displayed at the entrance to every surgical ward. This included information about the last time a patient had a fall on the ward, had developed a grade 3 or 4 pressure ulcer, or developed a venous thromboembolism (VTE) or urinary infections in patients with catheters.
- In March 2014 at the patient safety dashboard meeting it was reported the trust had exceeded the monthly and annual trajectory for category 3 and 4 pressure ulcers. They had reported 78 cases against an agreed maximum threshold of 18 cases for 2013-14.
- There had been improvements in the number of patient falls since February 2014. On ward 12 there had been five falls in the last six months.
- Data showed 98% of inpatients had received a VTE risk assessment on admission to hospital. This was against a target of 95%.
- At the time of our inspection there were no pressure ulcers grade 3 and above on any of the surgical wards at Dewsbury.

Cleanliness, infection control and hygiene

- Ward areas were clean and we saw that staff regularly washed their hands between patients and between interventions. Staff were bare below the elbows, in line with trust policy and national guidelines.
- All freestanding equipment in theatres was noted to be covered and dated when cleaned.
- Methicillin-resistant Staphylococcus Aureus (MRSA) rates for the trust were within expected limits. There had been one reported case of Clostridium difficile (C. difficile) for surgical wards in June 2014.
- Infection control information was visible in all ward areas, with each ward having an infection prevention and control information board. This information included how many days a ward had been free from C. difficile. On the wards we visited, we found there were no cases of C. difficile.
- All elective patients undergoing orthopaedic surgery were screened for MRSA and patients were isolated in accordance with infection control policies.
- Infection control audits were completed each month that monitored compliance with key trust policies such as hand hygiene. Most areas within surgery demonstrated compliance from April 2013 to the time of inspection.
- Nursing staff had received training in Aseptic Non Touch Techniques. This encompassed the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The unit participated in surgical site infection audits run by Public Health England. The last published results for October to December 2013 showed there were no surgical site infections relating to hip replacements.

Environment and equipment

- We observed that checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.

- Records showed equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- Theatre staff told us there were delays in the delivery of sterile surgical trays. During our observations in theatres we noted two trays for orthopaedic cases had gone 'missing' on their way to theatre. The order of the operating lists had to be changed to wait for instrumentation. Staff told us this was a frequent occurrence and that trays were received on the day of surgery, which didn't allow for any slippage.
- There was a dedicated day case building that housed two theatres. The waiting area provided a relaxed non-clinical atmosphere and was fit for purpose. A dedicated child-orientated recovery bay was also available for paediatric cases.

Medicines

- Medicines were stored correctly and securely on the wards and theatres.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Records showed that fridge temperatures were monitored daily on the wards.
- We observed nursing staff administering medications on the ward wore red aprons to minimise interruptions.

Records

- Care pathways were in use, for example, for patients who had suffered with a fractured neck of femur.
- The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Records we looked at were completed accurately.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Patient records were stored in trolleys at the end of each bay. These were locked when not in use.
- We saw in from the clinical governance meeting minutes (March 2014) themes from the trust wide audit on record keeping were shared. It was noted improvements in countersignature of deletions, alterations, author designation and author printed were identified.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most records we looked at showed patients' consent was obtained appropriately before any procedure and in accordance with the Department of Health consent guidance. However, in three records the consent form was signed on the day of surgery. This meant the patient had not received a copy of the page documenting the decision-making process before they arrived for the procedure.
- In one record, confirmation that the patient still wanted to go ahead with the procedure had not been completed.
- Patients told us they had been asked for their consent before surgery. They said the risks and benefits had been explained to them and they had received sufficient information about what to expect from their surgery.
- Some staff confirmed they had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, most staff showed a lack of awareness and knowledge in this area. The trust had identified the lack of training in its corporate risk register. An action plan was in place to deliver training to all clinical staff. Staff told us they received support and advice from the trusts safeguarding team.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take.
- Compliance with training for adult and children's safeguarding level 1 was 100% across all surgical areas. However, data showed that by May 2014 (Safeguarding Paper May 2014) only 62% of staff had completed level 2 in safeguarding adults training and 61% had completed safeguarding children's level 2 training.

Mandatory training

- The performance report for June 2014 showed that 92% of staff in the division of surgery were up to date with their mandatory training.
- Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.
- Trust data showed approximately 68% of staff in the division of surgery had received yearly resuscitation training. According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure

that clinical staff can undertake cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates. It was unclear whether staff in the outpatients department had received this training.

Assessing and responding to patient risk

- The surgical wards used the National Early Warning Scoring System, a recognised early warning tool for the management of deteriorating patients. Some wards were piloting an electronic system to record patients' vital signs, and this was used for early identification of a deteriorating patient. The electronic board informed staff if a patient's vital signs were deteriorating so that appropriate action could be taken.
- We saw a surgical safety checklist re-audit January 2014 had been undertaken. Information showed that of the forms audited at the Dewsbury site 36% had been fully completed. Compliance across the whole trust was 61%.
- We observed staff undertaking the 'five steps to safer surgery' procedures (World Health Organization checklist) in theatre two. Some of the steps such as timeout and sign out were performed and documented correctly. However, there was no evidence of any formal briefing and debriefing taking place before and after surgery. Staff also told us medical input in the process was variable.
- We were told a further audit of the WHO checklist had been undertaken in March 2014 we asked the trust to provide us with the results of the audit but these have not been given to us. An observational audit of the WHO checklist was planned for the end of July 2014.

Nurse staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken by the trust to reassess the staffing levels on wards and the trust was in the process of increasing them, including recruiting staff from abroad. This was to ensure that staffing establishments reflected the acuity or dependency of patients.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed roster. Staff reported good cross-department working.
- Ideal and actual staffing numbers were displayed on every ward we visited. Vacancy rates for the division at June 2014 were 10.36%. Bank and agency staff were used to fill any deficits in nursing staff numbers. Staff could also work extra hours.
- We found there were staffing vacancies on wards 14 and 15. Staff told us there were staff shortages, particularly at night. One patient on ward 14 indicated, "They are definitely short-staffed at night. I had to wait one and a half hours for my pain relief."
- Staffing levels in the Post Anaesthesia Care Unit (PACU) were below the British Anaesthetic and Recovery Nurse staffing guidelines. On the day of inspection we found two nurses to three patients who required airway support and were emerging from unconsciousness. The recommended staff ratio was 2:1 (two nurses/one patient). The anaesthetist/operating department assistant had to recover the patient. The team leader told us they would call for help from other staff members, but these were not recovery trained. This meant patients were being cared for by staff that were not skilled or suitably trained and the service did not follow best practice guidance.
- Nursing handovers occurred twice a day, using patient information from the ward electronic system. We observed a safe transfer and handover of a patient to PACU.

Surgical staffing

- There was an annual reduction in junior doctors resulting in gaps in the medical rotas across the service. Locums were being used to fill the gaps and there was a conversion to other posts such as clinical fellows and trust grade doctors. The division was also expanding nursing roles and had advanced nurse practitioners in post and in training. CQC intelligence monitoring report found the ratio of medical staff to occupied beds was as expected and showed no evidence of risk.
- Surgical consultants from all specialities were on call for a 24-hour period.
- There were a number of vacancies in anaesthetic junior rotas because of a national reduction in trainee posts. The clinical lead for anaesthetics told us rotas were being filled by locum doctors, which was posing a substantial financial risk. A workforce plan was in place that included a review of consultants working extra sessions, changes to shift patterns and recruitment of staff from abroad.
- The surgical divisional risk register showed there was understaffing at consultant level for oral and maxillofacial surgery. CQC had received some concerns regarding the service. We discussed this with the divisional management team who were aware of the

risks of not meeting waiting times and cancer pathways. Locum posts had been agreed as a short term measure and substantive appointments should be in place by November 2014. The trust reported that as an interim measure a local agreement was in place with a neighbouring trust for the referral of complex and trauma oral and maxillofacial patients when needed.

Major incident awareness and training

- Business continuity plans for surgery were in place. These included the risks specific to each clinical area and the actions and resources required a return to normal services.
- A trust assurance process was in place to ensure compliance with NHS England core standards for Emergency Preparedness, Resilience and Response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who may be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency. Staff were familiar with their role in an emergency response.

Are surgery services effective?

Requires improvement

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges. Other indicators showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, and the number of emergency admissions following elective admissions.

The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (CEPOD). However, there was no dedicated emergency surgical CEPOD theatre, which meant that there was a risk that urgent cases would not be dealt with in a timely manner putting patients at risk.

Processes were in place to identify the learning needs of staff and opportunities for professional development, although sometimes staff found it difficult to attend because of staffing pressures on the ward.

Evidence-based care and treatment

- Patients were treated based on guidance from the National Institute for Health and Care Excellence, the Association of Anaesthetists of Great Britain & Ireland and the Royal College of Surgeons. We saw discussion about NICE guidance in the minutes of the Clinical Governance meetings. For example, updates were given on revised guidance for negative pressure wound therapy for the open abdomen in the December 2013 meeting.
- The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (CEPOD). There was emergency/ acute theatre availability at Dewsbury Hospital every afternoon, seven days a week. Any emergencies in the mornings utilised an unused session or displaced an elective case.
- Enhanced recovery pathways were used for patients admitted for fractured neck of femur. This was in line with the British Orthopaedic Association and British Geriatrics Society guidelines. Data showed pre-operative assessment of patients by a geriatrician was better than the England average.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- Following an audit of pre-operative fasting times in adults scheduled for orthopaedic surgery, documentation had been amended including the pre-operative pathway, orthopaedic operation leaflets and clerking pro-forma to promote safe pre-operative fasting for surgical patients.
- Nursing staff did weekly audits on harm-free care, patient experience and the environment. Records showed good compliance in these areas.

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Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and these were recorded using a pain scoring tool.
- Most patients reported their pain was well-controlled. Patients recovering from surgery were provided with patient-controlled analgesia to enable them to control their pain.
- The trust had a dedicated pain team that provided advice and support to the wards.

Nutrition and hydration

- Fluid input and output records were used appropriately to monitor patients' hydration. We looked at a sample of records on the surgical wards, which were completed to a good standard. There were nutrition link nurses on wards who provided training and support to staff.
- Patients were screened using the Malnutrition Universal Screening Tool. When patients were at risk of malnutrition, records showed a referral had been made to the dietician.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied, depending on whether the surgery was in the morning or afternoon.
- Patient-led Assessments of the Care Environment scored the trust 88.7% for food.
- Menus showed that choices of gluten-free, vegetarian and soft diets were available. Most patients we spoke with were complimentary about the quality and quantity of food they received.

Patient outcomes

- There were no current CQC mortality outliers relevant to surgery. This indicated that there had been no more deaths than expected for patients undergoing surgery.
- The trust contributed to all national surgical audits for which it was eligible. National audit data for bowel and lung cancer showed outcomes were within expected ranges.
- The trust participated in the National Hip Fracture Audit. Findings from the 2013/14 report showed the trust was better than the expected England average in areas such as patients receiving a bone protection medication assessment, 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, 80% of fractured necks of femurs were seen within 48 hours compared with the national target of 87%.
- Day case surgery was performed below national expectation for several specialties, including orthopaedics (55%), general surgery (72%) and breast surgery (73%). The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.
- The average length of stay between December 2012 and November 2013 showed most surgical specialties were better than the national average, with the exceptions of trauma and orthopaedics.
- The trust participation rate and outcomes for the Patient Reported Outcome Measures for hips and knees had been below those reported nationally. There had been progress against the action plan targets since March 2013. Although remaining an 'outlier' on two of the procedures, the situation had improved over 2013/14 and is nearing the national norm.
- The trust was an outlier for emergency admissions following an elective admission. The divisional management team told us they were liaising with the public health doctor to fully understand the data and risk. Following these discussions an action plan would be developed. In the interim to mitigate the risk there was a group to support safe discharges through the use of a discharge check list.

Competent staff

- The trust had a target for the division to achieve 90% compliance for appraisal by the end of the year. Records for April – June 2014 showed that 67% staff in surgery had received an appraisal. The proportion of staff who received an appraisal in the last 12 months was as expected.
- We spoke with a junior doctor who told us they received good training and support from their seniors. They used the e-logbook, a web application that allowed them access to analyse their operative data and enabled their trainers to study the training performance. The GMC National Training Survey 2013 identified no risks in these areas.
- Revalidation and clinician outcomes were assessed and monitored by the Medical Deanery.

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Multidisciplinary working

- We observed effective multidisciplinary working on the wards. There was allocated physiotherapy and occupational therapy support and daily board rounds were carried out where the clinical care of every patient was reviewed by members of the multidisciplinary team led by the consultant managing the patients care. Staff told us there was effective communication and collaboration between teams who met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- Staff told us there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- Staff on wards 14 and 15 said there used to be a weekly multidisciplinary team meeting but that this had stopped because of staff shortages.
- Communication was sent to the GP electronically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken. However data showed only 31.1% of discharge letters had been sent to the GP within 24 hours which was below the target of 90%.
- There was also a backlog of un-typed clinical letters over five days. The divisional management team told us training was being provided for clinicians on the electronic discharge system and all urgent and cancer information was marked as a high priority. The management team gave assurances that all urgent letters were being completed within timescales. However, this meant there was a lack of clinical information available for example to the patient's GP. The management team were aware of the impact on patient care in terms of delayed treatment and results not being acted on which they had identified on the divisions risk register with a review date of August 2014.

Seven-day services

- Consultants were available on-call out of hours and would attend when required to see patients at weekends.
- Daily ward rounds were arranged for all patients. New patients were seen at weekends when necessary.
- Access to diagnostic services was available seven days a week, for example, x-rays, MRI and CT scans.
- There was an on-call pharmacist available out of hours. Pharmacy staff were available on site during the week.

Are surgery services caring?

Good

We observed positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received. Most patients we spoke with felt they understood their care options and were given enough information about their condition. There were services to ensure patients received appropriate emotional support.

Compassionate care

- We observed positive, kind and caring interactions on the wards between staff and patients. Staff spoke with patients and relatives in a dignified and caring manner. One patient on ward 12 said, "Very good experience, staff are very professional"; another patient said, "Excellent care all the way through my surgery." Patients on ward 14 and 15 were on the whole positive about the standard of care they had received but felt there were staffing shortages, particularly at night.
- The CQC Inpatient Survey 2013 did not identify any evidence of risk and was rated 'about the same' as other trusts.
- We observed staff introduced themselves appropriately and that curtains were drawn to maintain patient dignity. There were facilities on the wards for staff and relatives to have more sensitive conversations if required.
- Wards were organised, including single-sex accommodation, to promote privacy and dignity. There were no mixed-sex accommodation breaches in surgery between April and June 2014.
- The trust's Friends and Family Test inpatient response rate remained below the national average. We looked at data on individual wards, which showed that the majority of patients were 'extremely likely' or 'likely' to recommend the service to their family and friends.
- Each patient had a named nurse to ensure continuity of care.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards

had negative comments. The main negative themes were related to the poor state of Dewsbury Hospital. The positive themes related to the caring staff across all sites.

Patient understanding and involvement

- Most patients we spoke with felt they understood their care options and were given enough information about their condition.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure they had adequate support on discharge.
- In the Cancer Patient Experience Survey 2013 the trust scored in the highest 20% of trusts for patients being given a choice of different types of treatment. However, the trust scored in the lowest 20% of trusts for how staff had explained how the operation had gone in an understandable way.
- Patients on the surgical enhanced recovery programme completed a patient diary, which gave patients the opportunity to comment on how they were feeling and whether they were able to achieve their goals while recovering from surgery.

Emotional support

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

Are surgery services responsive?

Requires improvement

Surgery had systems in place to plan and deliver services to meet the needs of local people. The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.

We found that staff were responsive to people's individual needs, but that there were serious concerns over waiting times, such as the 18-week referral to treatment times, waiting for care once in hospital and the high number of medical outliers on surgical wards. The impact of delays in referral to treatment was evident in the number of complaints the trust had received.

Services were available to support patients, particularly those who lacked capacity to access the services they needed. Support was available for patients living with dementia and learning disabilities.

Information about the trust's complaints procedure was available for patients and their relatives. Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There was some evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.
- Capacity bed meetings were held daily to monitor bed availability in the hospital; they reviewed planned discharge data to assess future bed availability.
- During high patient capacity and demand, elective patients were reviewed in order of priority for cancellation to prevent urgent and cancer patients being cancelled.
- The orthopaedic team performed a high number of hip and knee replacements in response to the needs of the local population.

Access and flow

- The trust's bed occupancy rate was 85.3%; this was lower than the national average.
- Over the previous year there had been an issue with referral to treatment times. The patient safety dashboard meeting minutes (June 2013) stated that 86.5% of the admitted pathways completed in June 2013 were completed within 18 weeks against the 90% target. In a patient context, this meant that of the 3,158 admitted pathways completed in June 2013, 426 were over 18 weeks. Of this 426, 316 were permitted in line with the national 90% tolerance. We saw this theme continued and in meeting minutes from the Clinical executive group on 20 November 2013 a robust recovery

plan for ENT had been put in place. However at the time of our inspection we saw the trust was still not meeting the national 18-week maximum waiting time in orthopaedics, ENT, ophthalmology and urology. A recovery plan was in place including the use of waiting list initiatives to reduce the number of patients waiting by September 2014.

- The impact of delays in referral to treatment was evident in the number of complaints received, for example in one complaint a person stated, "I am 82 years old, have worked all my life I would like to get my eyes done before I am blind" (Trust Board Report – Six Monthly Review of Complaints April 2014). The review reported that the majority of complaints were "principally linked to the delivery of the response time target". This backlog in referrals to treatment was listed on the trust's risk register.
- The trust reported 304 last minute planned operations cancelled for non-clinical reasons. One patient was not treated within 28 days of a cancelled procedure. The trust was better than the expected targets in these areas.
- Patients were assessed by the multidisciplinary team, including an anaesthetist, before admission. This allowed staff to identify patients' care needs before their operation and have plans in place for their recovery.
- Discharge planning began at pre-operative assessment stage for elective patients and on admission to the unit for trauma or emergency patients.
- The division had outlier guidelines, which included criteria for the suitability of patients to be transferred. Concerns had been raised by staff on wards 14 and 15 relating to medical patients being cared for on surgical wards. Daily risk assessments were completed and a named medical consultant was allocated to review the medical patients on the ward to ensure consistency of their reviews.
- Staff told us capacity issues on the wards sometimes caused a backlog of patients in PACU, which meant some patients began their recovery in the operating theatre causing delays to subsequent cases. This had led to a patient complaint. The trust was aware that this was a problem, the Patient Experience Improvement Plan (29 April 2014) stated, "Trust aware of number of elective patients waiting a significant amount of time post-operatively in the Post Anaesthetic Care Unit (PACU) before being allocated a ward bed. This is an area where patients may be waiting on trolleys, in mixed gender areas, no toileting facilities with limited food provision".

Meeting people's individual needs

- Support was available for patients living with dementia and learning disabilities. The unit had dementia champions as well as a learning disability liaison nurse who could provide advice and support on caring for people with these needs. Not all staff had received training in dementia awareness.
- Patients with learning disabilities were provided with a VIP hospital passport. This document held all the relevant individual patient health details and personal choices, for use when they were unable to tell medical and nursing staff themselves.
- Patients using colorectal 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.
- A translation telephone service was available for patients for whom English was not their first language.
- There were multiple information leaflets available for many different conditions and procedures. These could be made available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at ward level and through the trust's Patient Advice and Liaison Service.
- From October 2013 to March 2014, across the surgical division, there had been 18 high grade complaints, 94 medium grade complaints and 159 low grade complaints. A theme for the low grade complaints was the multiple cancellations of appointments for ophthalmology. Overall, the top three themes were clinical treatment, staff attitude and dates of appointments. The category of clinical treatment covered a number of secondary subjects such as poor nursing/clinical care, delay in treatment, the coordination of treatments and falls." (Trust Board Report – Six Monthly Review of Complaints April 2014)
- There were many informal complaints received and the newly introduced integrated reporting process captured

the themes and learning from these. The surgical division received the highest number of complaints of all divisions, with waiting times for admission being one of the main causes for concern.

- Most staff told us they received feedback from complaints and concerns at staff meetings or through the monthly safety bulletin.
- The trust had introduced patient experience improvement plans to address themes and share learning from complaints, these were discussed at the Learning from Patient and Staff Feedback Group. Each ward/department had their own plan to address issues raised from complaints and these were monitored through the Patient and Staff Feedback Group.
- Complaints management information formed part of the chief nurse report to the Trust Board and included the number and grading of complaints, trends by division, the latest performance data and examples of service improvements.
- Examples of learning from complaints in the surgical division were the introduction of intentional rounding to include improved documentation, a dedicated pharmacy service to improve the discharge process with medication and the reconfiguration of the surgical floor.

Are surgery services well-led?

Requires improvement

The trust's vision, values and strategy had been cascaded to wards and departments. Some staff had a clear understanding of what these involved, but this was not the case in all surgical areas.

Risks at team and divisional level were identified and captured. There was some alignment between the risks on the risk register and what individuals said were on their worry list. However we saw some action plans were not fully implemented.

Staff were aware of their roles and responsibilities. There was good ward leadership and staff felt supported and had seen positive changes to improve patient care. Some staff reported a 'disconnect' between middle management and themselves, and felt there was a lack of communication and flexibility to support autonomous working. There were changes in management structures and reconfiguration of services that had led to low staff morale, particularly in theatres.

The service recognised the importance of patient and public views and there were mechanisms in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. The trust's values and objectives had been cascaded across the surgical wards and were visible on ward areas. Some staff had a clear understanding of what these involved.
- The clinical services strategy provided a number of challenges in the reconfiguration of services within the surgical division. Some staff confirmed they had been involved in the consultation process and had received regular communication; however, this was not the case in all areas.

Governance, risk management and quality measurement

- The division of surgery held monthly governance meetings. The meeting minutes showed complaints, incidents, audits and quality improvement projects were discussed and action taken where required, including feedback to staff about their individual practice.
- We saw an action plan had been developed as a result of three never events in the division of surgery. In the report on the actions 7 May 2014 we saw the division believed three out of the five steps to safer surgery were being undertaken. The safer surgery group agreed that they would oversee the implementation of steps one and five whilst improving compliance with steps two to four. We saw this action had been due to be completed by the 26 March 2014 and this was being reported as incomplete. It was unclear from the action plan when the division anticipated this would be completed and all the steps implemented.
- The safer surgery group monitored action plans for never events and managed subgroups tasked with implementing elements of the action plan. Minutes dated May 2014 showed changes had been made to the swab count policy and perioperative pathway.

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- We saw in March 2014 the division had developed an action plan for CQC compliance. On that we noted the division had identified issues in relation to not all wards having adequate staffing levels for service provision on the days the mock inspections had been undertaken. However we noted at the time of our inspection on some wards staffing levels still failed to meet minimum safe staffing levels.
- Risks at division level were identified and captured. There was some alignment between the risks on the risk register and what staff said was on their worry list. However we saw in some action plans were not fully implemented.
- The surgical safety checklist re-audit January 2014 concluded that over sequential audits "full form completion" levels had not improved and, in numerous sections, evidence of a reduction in full completion had been found. This meant actions put in place to address this had not managed to sustain improvements in practice.

Leadership of service

- Staff were aware of their roles and responsibilities. We found there was good ward leadership and staff said they felt supported and had seen positive changes to improve patient care. This was particularly the case on wards 14 and 15.
- Some staff said the matrons did not attend the wards regularly because they were mainly based at Pinderfields but did spend occasional days at Dewsbury.
- Medical and nursing staff spoke positively of each other and reported that working relationships were effective and supportive. However, there was some evidence of management–clinician divides, which were historical and never fully resolved.
- Some staff reported a 'disconnect' between middle management and themselves, and felt there was a lack of communication and flexibility to support autonomous working.
- There was low staff morale in theatres. Staff told us they were unsure of the future management structures and felt there was a lack of open and effective communication from managers about the reconfiguration of services. A new interim manager had been in post since May 2014 and action plans for improvement were in place, but were not yet fully implemented and evaluated.
- Staff sickness levels in surgery for April 2014 were 4.36% against a target of 4%.

Culture within the service

- Most staff reported an open and transparent culture on the surgical wards. They reported good engagement at ward level and felt they were able to raise concerns and these would be acted on.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.

Public and staff engagement

- A patient experience improvement plan for surgery had been developed in response to patient feedback. This showed action had been taken in areas such as communication, discharge planning and patient information.
- The NHS staff survey data showed the trust scored as expected in 11 out of 28 areas and better than expected in one area. There were negative findings in areas such as staff engagement, communication with senior management, job satisfaction and work pressures.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance, which included the collection of national data, audit and learning from incidents, complaints and accidents. A number of action plans had been developed, but some were yet to be implemented and evaluated.
- Some staff told us the trust board was making an effort to engage with staff and had attended open staff forums and the trust's 'listening in action events', where they had put forward their concerns and ideas for improvement.

Critical care

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides critical care at Pinderfields Hospital and Dewsbury District Hospital. There are 25 critical care beds in total. Dewsbury District Hospital provides 10 critical care beds, six in the intensive care unit and four in the acute high dependency unit. In addition, the critical care service at Dewsbury District Hospital includes Ward 20 (adjacent to the acute high dependency unit), with eight beds for patients requiring high dependency care.

It is planned that critical care beds will all be provided at Pinderfields Hospital from 2017. Patients and staff will move from Dewsbury District Hospital to use the newer facilities at Pinderfields Hospital. Dewsbury District Hospital will continue to provide high dependency care for patients who need this.

There is a critical care outreach service operating at Dewsbury District Hospital. The outreach service currently operates between 7.30am and 6.30pm on seven days a week. Outside these hours, cover is provided by staff in the critical care unit.

Summary of findings

We rated the services for critical care as good, although improvement was required for safety. There were systems, processes and practices in place to keep patients safe that were generally reliable. However, nursing and medical staffing levels were not always in line with the 'Core Standards for Intensive Care Units' and the daily monitoring of equipment was not consistently carried out.

The assessment, care and treatment of patients were delivered in line with current national standards and recognised evidence-based guidance. This included patient care in line with the national core standards for critical care units and National Institute for Health and Care Excellence (NICE) guidance. The care and treatment delivered achieved positive outcomes for patients. Outcomes were routinely monitored and measured, shared internally and externally, and used to make improvements to the service.

There was effective communication between the multidisciplinary team, appropriate and effective use of the critical care outreach team and the support given to patients and their families.

Patients and their families were positive about the care and treatment in the critical care unit. Patients were treated with compassion and respect and their privacy

Critical care

and dignity were maintained. As far as possible, patients were involved in making decisions about their care and treatment. Patients' families and visitors were treated with consideration and respect.

The service was responsive to the needs of patients and had caring staff. There was appropriate provision of critical care services to meet the needs of local people. Access to the critical care unit was based on clinical need, including patients who needed planned critical care following elective surgery. There was a low rate of cancellation of planned surgery arising from a lack of beds in the critical care unit.

Staff were positive about the leadership within the critical care service. They felt that their managers were in touch with the challenges faced by the service. Most staff felt there should be more visibility of the chief executive and the executive team. Risks were identified, understood and were being managed. This included risks around staffing and the environment of the critical care unit.

Are critical care services safe?

Requires improvement

The critical care service had effective arrangements for reporting safety incidents and staff told us they understood how and what to report. However, we did find a recent incident that had not been reported.

There were systems, processes and practices in place to keep patients safe that were generally reliable. This included systems to ensure the cleanliness of the critical care unit and to reduce the risk of infection for patients. However, there was a lack of monitoring of the daily checks of some equipment.

Risks were assessed and monitored and appropriate action taken in response to changes in risk levels. This included individual patient risks, such as the risk of sepsis or pressure ulcers, as well as other risks, such as staffing levels. There were plans in place to manage and mitigate foreseeable risks, including changes in demand for critical care, bad weather and major incidents.

Nursing and medical staffing were not always in line with 'Core Standards for Intensive Care Units' (The Intensive Care Society 2013), which are national standards that apply to all critical care units. The risks associated with this had been recognised and action plans were in place. However, it was not always possible to deal with staffing gaps quickly.

Incidents

- There were no never events or serious untoward incidents reported in the critical care service in the last 12 months.
- Incidents were usually reported in line with the provider's policies and external guidance. For example, if a patient developed a severe pressure ulcer, this was reported in line with the trust's policy and NHS Safety Thermometer guidance.
- We found one recent incident that had not been reported. This was an incident where a patient had accidentally removed their breathing tube. This should have been reported according to the trust's policy. The acting unit manager told us they were not on duty at the time of the incident. They said that staff should know this was a reportable incident and they would look into why it had not been reported.

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- Staff knew how to report incidents and could describe a range of incidents they would report. They also told us they had feedback and lessons learned were discussed at team meetings. We saw evidence of this in the minutes of staff meetings.
- There were regular mortality and morbidity meetings for medical staff to discuss, and learn from, patient deaths. There were no arrangements for the wider multidisciplinary team to take part in these meetings, though feedback was passed on through other governance meetings.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. Safety Thermometer information was clearly displayed at the entrance to the critical care unit. This included information about pressure ulcers, falls and infections.
- The Safety Thermometer information showed positive results because there was a low incidence of falls, pressure ulcers and infections.

Cleanliness, infection control and hygiene

- The environment in the critical care and high dependency units was visibly clean.
- We observed nurses and doctors cleaning their hands when required, such as before and after contact with a patient. We saw all staff followed the trust's policies regarding 'bare below the elbow' and the use of disposable gloves and aprons in clinical areas.
- The Safety Thermometer information showed that there had been no instances of Clostridium difficile infection since August 2013. There had been no MRSA infection in the last 12 months. C. difficile and MRSA are bacteria responsible for infections that may be picked up by patients in hospitals and can sometimes be difficult to treat.
- Staff from the microbiology department visited the units every week to check on any infection risks and could be called in if needed for advice and support.

Environment and equipment

- The critical care unit did not meet guidance from the Department of Health, particularly regarding the space available for each bed and the lack of ceiling mounted pendants to accommodate equipment and medical gases. (Department of Health- Health Building Note (04-02):Critical Care Units)
- We found equipment was stored in a bed space in the critical care unit on the day of our visit. The acting unit manager told us this was usually stored in a side room but had been moved because the side room was needed for a patient. We found there was a lack of storage space within the unit.
- There was an electronic display board in an area used by patients. The display board showed details of patients' location within the high dependency unit and could be read by anyone using the area. This meant that patients' personal information was not treated confidentially.
- There was a programme in place for the regular maintenance of equipment. Staff told us that any repairs reported were usually dealt with promptly.
- Checks of resuscitation equipment were carried out and staff recorded the checks and any action required. We found gaps in the records for a trolley of airways and associated equipment. This meant that there was a lack of assurance that daily checks had not been completed on this equipment. The records noted missing items on several days in July 2014, but no indication of what the items were or what action had been taken to replace them. When we brought this to the attention of the acting unit manager, the missing items were ordered and we were told they would be replaced that day. There was no routine monitoring of the daily check records to ensure they had been fully completed and that appropriate action was taken to ensure all equipment was available.

Medicines

- The pharmacist support provided met the requirements of the core standards for critical care units.
- Medicines, including controlled drugs, were stored in a designated room in the critical care unit. The temperature in the medical room was not checked or monitored. The room felt very warm on the day of our visit and there was no air conditioning or windows. Some medicines must be stored at temperatures below 25°C to ensure their potency and stability.
- There were records of the daily checks of the temperature of the fridge used to store medicines. The records showed the temperatures were always within the required range. However, the maximum and

minimum temperatures were not recorded. This meant that staff may not be aware if the fridge temperatures had been too low or too high at any time during the previous 24 hours.

Records

- Standardised nursing documentation was kept by the end of the patient's bed. We reviewed the records for two patients. Observations and assessments were consistently recorded and appropriate risk judgements were made in terms of the frequency of some observations.
- Medical records were tracked electronically so their location was always known. Medical records were stored in drawers by the end of each patient's bed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us their consent had been sought before care or treatment was provided. One patient said, "They always ask me before anything happens. If I don't understand, I can ask them about it."
- Patients' records showed that consent to care and treatment had been obtained from patients, or from the relatives when necessary. This included consent to decisions not to resuscitate the patient.
- Staff said they had received training and guidance about the Mental Capacity Act 2005 and could give examples of when patients may lack capacity to give informed consent.
- There were no patients affected by the Deprivation of Liberty Safeguards (DoLS) at the time of our visit. Staff were aware of DoLS and knew who to contact for further guidance. The critical care matron told us that possible deprivation of liberty would be discussed with the multi-disciplinary team. Decisions would be taken in the patient's best interests. They gave the example of the use of hand mittens to prevent patients dislodging equipment that was providing life-saving treatment.

Safeguarding

- All staff had received training in safeguarding adults and children as part of their mandatory training. Staff could give examples of what they would consider abuse and knew how to report their concerns.

Mandatory training

- There was a programme of mandatory training in place for all staff. This included safe moving and handling of patients, prevention and control of infection, and safeguarding adults and children.
- Staff said they were supported to attend mandatory training when required.
- Information provided by the trust showed that most staff (87%) in the critical care service at Dewsbury District Hospital had completed mandatory training as required.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) was implemented throughout the trust in March 2013. NEWS is based on a scoring system where a score is given to physiological measurements already undertaken when patients are being monitored in hospital. NEWS is used to inform and support clinical judgements and decisions regarding the treatment of patients.
- The use of NEWS in the trust was monitored by audits in September 2013, December 2013 and March 2014. Issues identified and actions required were fed back to staff through governance meetings.
- Staff were using a recently implemented electronic system with a handheld device to record patient observations. Data from the handheld devices was sent to a portable electronic 'tablet' device. This displayed data for all patients so that medical and nursing staff could access this easily.
- Staff told us they liked the new system. They found it useful that the device showed when patient observations were due and overdue. They reported that the device was quicker to use, more accurate and more reliable than a paper recording system.
- Patients' records showed that individual risks were identified and monitored, such as the risk of developing pressures ulcers, blood clots and sepsis.

Nursing staffing

- We found the nursing staff covered the critical care unit, the acute high dependency unit and the adjacent Ward 20 which had eight beds for patients requiring level one high dependency care. The levels of critical care were determined using guidance from the Intensive Care Society. A level one patient typically requires less complex care, though at a more enhanced level than can usually be provided on a general ward. Level two

and three patients usually require more complex, intensive care and treatment. Level three patients require a nurse/patient ratio of a minimum of 1:1, and level two patients a minimum of 1:2.

- On the day of our visit there were four patients in the critical care unit, three assessed as level three and one as level two. There were four patients assessed as level two in the acute high dependency unit and four level one patients in Ward 20. Four beds in Ward 20 were closed because of a lack of staff. These beds had been closed for the previous week after a risk assessment of the nursing staffing levels.
- The planned staffing was for six nurses plus a healthcare assistant, which was sufficient to provide the minimum staffing ratios. However, there were three nurses absent because of sickness. The acting manager and the clinical nurse educator were providing clinical support, bringing the total of nurses on duty to five. This level of staffing did not meet the core standards from the Intensive Care Society. Staff told us there had been previous occasions when the staffing levels fell below the core standards.
- The nursing staffing on the day of our visit appeared insufficient to allow for a new admission to the critical care unit. The acting unit manager told us that they very rarely refused an admission because of a lack of beds or staff. They said they would accommodate a new admission by moving patients from critical care to the high dependency unit if possible, and by using bank or agency staff.
- The core standards were not met regarding a supernumerary clinical coordinator on duty for all shifts. The acting manager told us there was sometimes a supernumerary clinical coordinator, depending on patients' needs and staff availability.
- On the day of our visit there was no supernumerary clinical coordinator on duty. The responsibilities of this role included the coordination and supervision of nurse staffing. We found when we visited the critical care unit that the acting manager was busy arranging cover for staff sickness. This meant they were not always available to provide hands-on nursing care.
- The sickness rate for nursing staff was reported as 13.9% at the time of our inspection, which is high compared with the sickness rate of 3.4% for NHS staff in 2013'according to the Office for National Statistics). The sickness rate had been high (above 10%) for the previous six months. The acting unit manager told us that this was partly due to three staff on long term sick leave.
- There were seven (whole time equivalent) vacant nurse posts in the critical care service. Recruitment to these posts was ongoing. Staff told us that some nurses had left after the plans to move critical care to Pinderfields Hospital were announced.
- The acting unit manager said that agency staff were regularly used to cover two or three shifts per week. We saw that the acting unit manager was able to specify when booking agency staff that they must have relevant training and experience in critical care.
- Staff told us they were frustrated by being moved to other areas in the hospital to provide cover. They said this was usually healthcare assistants or band five nurses (band five is the first level for qualified nurses). One member of staff said, "It can happen every day some weeks. We think we're fully staffed and then someone gets moved."
- The matron for the critical care service told us that patients' needs were always met by the nursing staffing levels. Other staff said, "It looks worse on paper – it is safe" and "Staffing has got worse in the last 12 months, but we always seem to manage."
- The high sickness rate and the vacant posts had a significant impact on nursing staffing in the critical care service at Dewsbury District Hospital. This had been identified and assessed as a risk by the trust. The action to mitigate the risk was the ongoing recruitment, using the clinical nurse educator to provide cover, the use of bank and agency staff and the closure of four level one beds in Ward 20. Also, in the longer term, the planned move to Pinderfields Hospital.

Medical staffing

- The critical care unit was a 'closed' unit, meaning that admissions, care and discharges were led by a consultant in intensive care medicine. This model has been shown to improve mortality and morbidity for critical care patients.
- The acute high dependency unit was an 'open' unit, meaning that consultants or registrars in other specialities in the hospital could arrange admission and lead the care and discharge of patients. Staff told us this sometimes led to inappropriate admission of patients who were assessed as needing level two critical care but

who did not meet the criteria for this. Staff said there were sometimes delays in patients receiving critical care treatment because they had to wait until an intensive care consultant was available. There were sometimes problems with patients being seen and reviewed at weekends because of a lack of doctors available to do this.

- Consultants in intensive care medicine were available during weekdays, but not always at night or at weekends. This meant that patients were not always reviewed within 12 hours of admission by a consultant in intensive care in line with the core standards. It also meant that the core standard of a consultant in intensive care medicine available at all times who is able to attend within 30 minutes was not met.
- Medical staff told us the risks associated with the lack of availability of intensive care consultants were recognised and mostly effectively managed. They said, "The default position is that gaps in the intensivist's rota are covered by anaesthetists with critical care skills and experience" and "It's a safe system, even if it's not ideal."
- Locum consultants were sometimes used to provide cover. One of the medical staff commented that locums did not always provide such a good quality of care and service as the permanent staff. A nurse said, "Locums can cause problems – we don't get the same standard of care and handovers aren't as good."
- The consultants' work pattern did not meet the core standard of consultants working five-day blocks of day shifts to provide continuity of care.

Major incident awareness and training

- The major incident policy for the trust included details of how the critical care unit would be involved in the event of a major incident. The major incident policy highlighted specific local risks, such as low temperatures, heavy snow and local industrial accidents.
- There was a contingency plan in place to allow for an influx of patients requiring critical care.
- The acting unit manager told us there had been practice responses to test the major incident policy. Lessons learned had been fed back to staff.

Are critical care services effective?

Good

The assessment, care and treatment of patients were generally delivered in line with current national standards and recognised evidence-based guidance. This included patient care in line with recognised research and the national core standards for critical care units.

The care and treatment delivered achieved positive outcomes for patients. Outcomes were routinely monitored and measured, shared internally and externally, and used to make improvements to the service.

Staff were qualified and competent to carry out their roles safely and effectively in line with best practice. Medical, nursing and therapy staff were suitably qualified and experienced to understand and meet the needs of critically ill patients. Staff worked together as a multidisciplinary team to ensure coordinated and consistent care for patients.

Evidence-based care and treatment

- Patients generally received evidence-based assessment, care and treatment in line with recognised guidance, standards and best practice. The care of patients in the critical care unit was led by a consultant in intensive care, in line with the national core standards. The acute high dependency unit did not operate in the same way. Patients had access to a consultant in intensive care though their care was led by consultants of different specialities. The potential impact of this was that patients may be inappropriately admitted and may experience delays in seeing a consultant in intensive care.
- Care bundles were in use. Care bundles are groupings of best practices regarding a care intervention or a disease process. Individually the best practices can improve the care and the outcome for patients. However, when applied together they may result in substantially greater improvement. A care bundle gives a standard approach to delivering these core elements of care. Research has shown that the use of care bundles improves patient care and outcomes.

Critical care

- We saw ventilator care bundles in use in the critical care unit. The use of the ventilator care bundle was monitored every day using an audit tool in each patient's medical notes.
- There were monthly audits of all care bundles used. This was to ensure that all elements of the bundle were applied together because evidence shows this to be the most successful approach.
- An end of life care bundle had been developed specifically for patients in the critical care unit. This included guidance for the withdrawal of treatment and effective pain relief. The end of life care bundle referred to national guidelines and published research.
- The physiotherapy service for critical care patients met the core standards relating to assessment and treatment of patients in critical care units. This was in line with NICE guidance. However, the physiotherapy service did not meet the core standard or NICE guidance regarding patients having a rehabilitation prescription on discharge from the critical care unit. A senior physiotherapist told us they were aware of the need for this and they were currently looking at how this could be implemented.
- There was an operational policy in place for the critical care service that had been recently reviewed and updated by the critical care management team. The policy was based on national standards for critical care units.

Pain relief

- There was a specialist nurse available to advise and provide support with pain relief for patients in critical care.
- We saw that patient observations included assessing and monitoring their level of pain. Pain relief medication was reviewed regularly.
- Staff told us there were close links with the palliative care team. End of life care included assessment of the patient's pain and how effective pain relief could be achieved.

Nutrition and hydration

- Patients' nutritional needs were assessed, including their risk of inadequate nutrition and dehydration. We saw that nutritional assessments were completed and regularly reviewed and updated.
- There was input and support from Speech and Language Therapists (SALT). The current SALT provision was not meeting the national core standard of patients receiving the therapy required for a minimum of 45 minutes per day, five days per week of therapy. However, the SALT team was being redesigned to improve the service and links to critical care, and to meet the national core standards. This included the development of a specialist intensive care SALT who would spend half their time at Dewsbury and half at Pinderfields critical care services.
- Patients were referred to the SALT team when the decision to wean them from the ventilator had been made. This was so that the patient could have an assessment of their swallowing and communication needs.
- Support from a dietician was available every day. A dietician told us they aimed to attend the multidisciplinary ward round each day but sometimes could not do this due to other pressures on their service.
- Staff told us that the monitoring of patients fluid intake and output was to be added to the electronic system. Staff said this would make the monitoring more accurate.

Patient outcomes

- Critical care services at Dewsbury District Hospital contributed to the Intensive Care National Audit and Research Centre (ICNARC). ICNARC collects data from participating critical care units, such as average occupancy, death rates and readmission of patients to the unit within 48 hours of transfer to a hospital ward. ICNARC provides feedback to each unit so that hospitals can use the results to make improvements to patient care.
- The ICNARC data for 2013 showed that the rate of unplanned readmissions to the critical care unit within 48 hours of discharge was below (better than) the CRG threshold. The low rate of unplanned readmissions indicated that patients were discharged from the unit at an appropriate point in their progress and to a suitable ward environment.
- Nursing and medical staff took part in the West Yorkshire Adult Critical Care Operational Delivery Network. This local network includes NHS and independent providers of critical care services in the region. The members of the local network work collaboratively to share learning, experiences, skills and best practice for the benefit of critical care patients and staff.

Critical care

- In June 2014, the trust reported that the critical care facilities were the best performing within the local network for length of patient stay and bed availability. The trust reported this was from results from WYACCOD.

Competent staff

- There were appropriately qualified and competent staff in the critical care unit. The care was led by a consultant in intensive care medicine. Although medical staff cover was sometimes provided by consultant anaesthetists rather than consultants in intensive care, the anaesthetists had appropriate skills and experience in critical care. 56% of the nurses working in the Dewsbury District Hospital critical care unit had a post-registration qualification in critical care nursing. This was above the core standard of 50% of nurses with a post-registration qualification.
- The role of advanced nurse practitioner (ANP) was being developed. The role of the ANP is to support the critical care team by carrying out many traditional medical tasks while maintaining a nurse focus. The ANP can carry out physical assessment and diagnosis as well as tasks such as advanced airway management and non-medical prescribing. There was an ANP in post who was looking at how the role could be best used within the critical care service. It was planned that the ANP would be used to provide 24-hour, seven-day cover to support the medical staff rota.
- There was a clinical nurse educator who worked at both Pinderfields and Dewsbury District Hospitals. The clinical nurse educator was appropriately qualified for their role. There were occasions when the clinical nurse educator was needed to provide nurse cover. This meant they would not be available to fulfil their role and responsibilities as clinical nurse educator on these occasions.
- Healthcare assistants had received specific training in critical care, such as relevant National Vocational Qualifications and in-house training about safe and effective monitoring of patients.
- Induction for nursing staff included a six-week period of supernumerary working followed by a six-week period of supervised practice. Staff told us the induction period could be extended until they felt confident to provide safe care for patients.
- Training in moving and handling was specific to the needs of critically ill patients. This was necessary to ensure that staff could safely move patients who were attached to life-saving equipment, such as ventilators.
- Nursing staff told us they had an annual appraisal. This was used to identify their training and personal development needs as well as to assess their performance.
- Information provided by the trust showed that in June 2014 just over 80% of nursing staff in the critical care service had received an appraisal in the previous 12 months.

Multidisciplinary working

- The multidisciplinary team in the critical care service included physiotherapists, speech and language therapist, dietician, microbiologist and pharmacist. We found these staff were of suitable seniority and experience to understand and meet the needs of critically ill patients. Other specialists were available as required, such as a nurse specialising in pain relief and a tissue viability nurse.
- We saw from observation and from patients' records that specialists and therapists were used to provide timely and effective advice, care and support.
- There was a daily multidisciplinary ward round to discuss patients' care and treatment and the expected outcomes. It was not always possible for all members of the team to be involved in the ward round. However, there were other opportunities for timely and detailed multidisciplinary discussions regarding individual patient care and treatment.
- Staff, including therapists, told us there was good multidisciplinary working in the critical care unit and the acute high dependency unit. A physiotherapist said, "The critical care staff work well with the physios and patients really benefit from that."
- Patients were sometimes transferred to the critical care unit at Pinderfields Hospital. Both critical care units used the same documentation to record patient care and this helped to ensure a smooth handover.
- All patients transferred from the critical care unit to the wards were seen by the critical care outreach team within 24 hours of their transfer. This was to support the patient and the ward staff and ensure the patient's care was continuing as planned.
- Patients were offered follow up appointments at an outpatient clinic, (run by the outreach team), if they had

been in the critical care unit for more than seven days, or had been ventilated for more than four days. This was because patients may experience stress or have post-traumatic stress disorder after a stay in a critical care unit. Patients attending the clinic could be referred to the clinical psychologist if required.

Seven-day services

- Intensive care consultants were not available on site seven days a week. Advice and support from intensive care consultants at Pinderfields Hospital at weekends could be sought by telephone if necessary.
- The critical care outreach team was available seven days a week.
- Some multidisciplinary services, such as speech and language therapy and dietician services, were available five days, Monday to Friday.

Are critical care services caring?

Good

Patients were treated with compassion and respect and their privacy and dignity were maintained. As far as possible, patients were involved in making decisions about their care and treatment. Patients' families and visitors were treated with consideration and respect. Families were involved in the care of patients where possible and were consulted about decisions where the patient was unable to provide consent.

After leaving the critical care unit, patients continued to receive support from the critical care outreach team. Support was offered to the relatives of patients who had died in the critical care service.

Patients and their families spoke positively about the care they had received.

Compassionate care

- Throughout the inspection we observed how staff engaged with patients and their families. Staff treated patients and their families with compassion and respect. We saw staff responding compassionately to patients' pain and discomfort.
- A patient in the acute high dependency unit said, "The staff here are all lovely and kind, nothing is too much trouble for them."
- We spoke with one family about the care and support being provided to the patient. They spoke highly of the care provided.
- Patients' privacy and dignity were maintained. Curtains were used around bed areas while care was delivered. A family member visiting a patient told us that the patient's dignity was always maintained.
- The entrance and waiting area for visitors was separate from the unit and entry was controlled by staff. This meant that patients' privacy was protected. It also meant that visitors did not see patients being admitted to the unit, which could be distressing.

Patient understanding and involvement

- Because of the nature of the care provided on the critical care unit, patients could not always be directly involved in their care. We heard staff explaining to patients what was happening, even when the patient was not able to respond.
- A patient's family member said, "We've been kept well informed throughout. The doctors are good at putting things in simple language for us." Another family member said, "They've involved (patient) as much as possible."

Emotional support

- Following admission to the critical care unit, medical staff arranged to meet with patients' relatives to explain the care, treatment and expected outcome for the patient. Relatives we spoke with said they had been kept fully updated about the patient's treatment and condition.
- The chaplaincy service within the hospital included visiting and listening, and bereavement support.
- Visiting times allowed for a rest period for patients during the afternoon, although there was flexibility to accommodate the needs of patients and their families.
- Facilities provided for patients' families included drink dispensing machines in the waiting area and a room for overnight stays.
- Patients discharged from the critical care unit were invited to attend a monthly outpatient clinic run by staff from the critical care service. Patients could be referred from the clinic for psychological support if this was needed.
- A nurse told us that relatives of patients who had died in the critical care unit were invited to an informal meeting held twice a year. The meeting was an opportunity to remember patients and talk with staff.

Critical care

Are critical care services responsive?

Good

There was appropriate provision of critical care services to meet the needs of local people. Access to the critical care unit was based on clinical need, including patients who needed planned critical care following elective surgery. There was a low rate of cancellation of planned surgery arising from a lack of beds in the critical care unit.

Patients were discharged from the critical care unit at an appropriate stage and to a suitable ward environment. Patients were not usually transferred from the critical care unit to the wards during the night. We found some patients experienced delays of more than four hours when waiting to be transferred to a ward.

There were arrangements to meet people's individual needs, including access to specialist intensive care, spiritual care and interpreter services.

Service planning and delivery to meet the needs of local people

- The critical care service was part of the West Yorkshire Adult Critical Care Operational Delivery Network. This local network monitors bed capacity in critical care units in the area and liaises with hospital and ambulance trusts so that patients can be directed to suitable available beds.
- Information provided by the trust showed that no critical care beds at Dewsbury District Hospital were closed for the period between May 2013 and May 2014. This meant the service was fully available.
- Patients were transferred to other critical care units if specialist intensive care was required that could not be provided at Dewsbury District Hospital. There were agreements in place to ensure that these patients were returned to Dewsbury District Hospital critical care unit once their specialist intensive care treatment was completed. The return of patients to the critical care unit was planned so that a bed would be available for them.
- The critical care outreach team provided critical care support to patients on the general wards at Dewsbury District Hospital. The team provided cover between 7.30am and 6.30pm seven days a week. Outside these hours, support was provided from the critical care unit.
- Staff in the outreach team were able to refer patients directly to the critical care unit, which meant that patients could be transferred promptly if further critical care support was needed.
- If a patient needed a critical care bed but there was none immediately available, staff from the outreach team would stay with the patient. This meant the patient's care and support was managed by appropriately trained staff until a critical care bed was available.

Access and flow

- The critical care unit had six beds, including two in single rooms. The beds were used for patients requiring level two or three critical care (as determined using the Intensive Care Society guidelines).
- The critical care unit did not admit patients who required level one care (sometimes called high dependency). Patients needing this level of care were treated in the adjacent Ward 20 high dependency unit.
- Admissions to the critical care unit were usually emergency admissions. Patients requiring planned admissions following elective surgery were usually accommodated at Pinderfields Hospital.
- Admissions to the critical care unit were based on clinical need and were arranged through discussion with the intensive care consultant on duty.
- Information provided by the trust showed that average occupancy was around 98% for level two patients and 74% for level three patients during the period June 2013 to June 2014. The national average occupancy rate for critical care units (levels two and three combined) was 83.4%.
- Information provided by the trust showed that the number of elective operations cancelled because of a lack of critical care beds was low (seven in total across the trust) between May 2013 and March 2014.
- The core standard, and the trust's policy, is for patients not to be discharged from the unit between 10pm and 7am. This is because patients perceive it as unpleasant to be moved from critical care to a general ward outside of normal working hours. Discharges overnight have historically been associated with higher mortality. Information provided by the trust showed that from June 2013 to June 2014 four patients were discharged out of hours. This figure is acceptable when compared with ICNARC data from other critical care units.

Critical care

- The core standard, and the trust's policy, is for patients to be discharged within four hours of the clinical decision that they are ready to move to a ward. This is so patients are moved without unnecessary delay to a more suitable environment. Managers told us that the number of delays had been reduced in the last 12 months. This had been achieved by implementing a new procedure with a clear escalation process to ensure that patients are moved within the four hours.
- Information provided by the trust showed fluctuations in the number of delayed discharges, though an overall reduction since June 2013. The ICNARC data for 2013 showed that the number of patient discharges delayed by more than four hours was below (better than) the Critical Reference Group (CRG) threshold. The CRG thresholds are used by ICNARC to define the standards expected in adult critical care units.
- Information provided by the trust showed that there was a low number of patients transferred from the critical care unit for non-clinical reasons. Non-clinical transfers are those made necessary because of lack of capacity, rather than clinical transfers to other units where more specialist care can be provided. Non-clinical transfers are an avoidable risk that can be reduced by effective local and networked planning.

Meeting people's individual needs

- Patients were sometimes transferred to other critical care units for specialist care, such as for certain renal or cardiac conditions. There were service-level agreements in place with other trusts to define the service to be provided and the expectations for both trusts.
- Translation services were available for patients who did not have English as their first language. Staff said it was usually possible to rely on family members to translate or there were some staff who could interpret. Staff knew how to access translation services if necessary.
- If a patient with a learning disability was admitted to the critical care unit, staff would contact the trust liaison person for advice and support.
- The chaplaincy service within the hospital provided a range of spiritual care including visiting patients at their bedside. The chaplaincy service also provided advice and guidance to staff about diet, medicine and care with dignity for patients of different faiths. There was a faith centre in the hospital providing suitable facilities for people of different faiths.

Learning from complaints and concerns

- Information about how to make a complaint, raise a concern or express appreciation was displayed in the waiting area outside the critical care unit. The information leaflets did not indicate how to obtain the information in other languages.

Are critical care services well-led?

Good

Staff were positive about the leadership within the critical care service. They felt that their managers were in touch with the challenges faced by the service. Most staff felt there should be more visibility of the chief executive and the executive team.

Risks were identified, understood and were being managed. This included risks around staffing and the environment of the critical care unit.

Feedback from patients and their families was actively sought and improvements were made in response to their comments. Staff felt able to raise concerns or ideas for improvements and generally felt they were listened to.

Vision and strategy for this service

- There were plans in place to reconfigure the critical care services by 2017. Patients requiring general intensive care and acute high dependency care would all be at Pinderfields Hospital. The unit at Dewsbury District Hospital would be for high dependency patients only.

Leadership of service

- The critical care service staffing structure included the clinical lead and the matron who had responsibility for overseeing the service at both Dewsbury and Pinderfields hospitals. There was a unit manager for the critical care service at Dewsbury District Hospital.
- Most staff told us they felt their managers were in touch with the challenges faced by the service and had confidence in the leadership of the service.
- Staff were aware of the Chief Executive and the executive management team. Most staff had met the Chief Executive, though they felt there could be more visibility of the Chief Executive and the executive management team at ward level.

Critical care

Governance, risk management and quality measurement

- The clinical lead and the matron were clear and open about the challenges for critical care services within the trust and the priority areas for action.
- Discussions around risk and service improvement were held at clinical governance meetings. Risks identified included staffing, the environment of the critical care unit and the provision of the clinical nurse educator.
- Staffing risks were being addressed by ongoing recruitment. Where possible, it was planned to recruit skilled critical care nurses. If less experienced nurses were recruited, there were suitable preceptorship and induction programmes in place.
- The provision of the clinical nurse educator did not meet the core standards for critical care units. The core standard is for one whole time equivalent clinical nurse educator for 75 staff. There was one clinical nurse educator in post who covered both Pinderfields and Dewsbury District Hospitals, around 150 staff in total. There were times when the clinical nurse educator was pulled away from their role to cover staffing shortfalls, reducing the time available for their clinical educator responsibilities. There were plans to review this provision and look at options.

Culture within the service

- Medical, nursing, therapy and administration staff all reported good team working within the critical care service. Staff told us, "I love my job, despite all the frustrations. It's a good place to work and a good trust" and, "We're a good team. We pull together and I think we give good care."
- Staff said that communication was generally good. Therapists felt that communication could be improved by more involvement in daily ward rounds.
- Staff told us they generally felt respected and valued by their team leadership, though not always by the wider organisation. Staff felt able to take concerns or ideas for improvement to their line managers and said appropriate action was taken. A common theme among staff was the frustration felt at being moved to other areas of the hospital to cover staff shortages.

Public and staff engagement

- Feedback and comments from patients and relatives were sought using questionnaires, a suggestion box and invitations to attend the outpatients' clinic. The acting unit manager told us that feedback was nearly always positive. Comments from patients and relatives were shared with staff.
- Patients and relatives were invited to attend events held by the local critical care network, where they could feed back any comments about the service they had received and suggestions for improvement. This was relayed back to hospitals in the network so that action could be taken to make improvements to the service.
- The Friends and Family questionnaires were used. However, the acting unit manager told us the questions were not really tailored for critical care and so the results were not always reflective of other feedback received.
- Staff told us they generally felt able to raise concerns or ideas for improving the service with managers and felt they would be listened to. They had opportunities through appraisal, team meetings, ward rounds or informal discussions.
- Staff consultation had started regarding the changes to the critical care service in the next three years. This meant that staff were aware of the plans, though there had been some negative impact in that some staff had left because of perceived uncertainty about jobs.

Innovation, improvement and sustainability

- Staff had annual appraisals when individual objectives were planned and progress discussed. This included objectives focused on improvement and learning.
- There was a focus on continuous quality improvement through internal and external monitoring and audits.
- Staff told us about improvements made to patient care and outcomes by better use of antibiotics. This had been achieved through multidisciplinary working.

Maternity and gynaecology

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides women's services over three sites. There are obstetric-led units at Dewsbury District Hospital and Pinderfields General Hospital, and a midwife-led unit at Pontefract General Hospital. There are community midwifery services across all sites. The service includes early pregnancy care, antenatal, intrapartum and postnatal care.

Between June 2013 and May 2014 there were 2374 births at Dewsbury maternity unit.

The inspection of Dewsbury District Hospital included the antenatal clinic, the antenatal day unit, an antenatal and postnatal ward, transitional care, the delivery suite, two obstetric theatres and a four-bedded recovery ward. We spoke with 13 women who used the service and 22 staff, including midwives, doctors, consultants and senior managers. We also held meetings with midwives, doctors and consultants to hear their views of the service they provide. We observed care and treatment, inspected 13 sets of care records and reviewed the trust's audits and performance data.

We reviewed information about the population of Kirklees and found 18.2% of the population belong to non-white ethnic minorities. The average proportion of Black, Asian and minority ethnic residents in Kirklees is higher than that of England (14.6%). Of all 362 Local Authorities in England, Kirklees is ranked as the 77th most deprived in England.

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

Maternity and gynaecology

Summary of findings

We rated the maternity service as good for effectiveness, being responsive and caring, but improvements were required for safety and well led. Most areas of the maternity unit were visibly clean; surfaces in the delivery suite required attention. There were effective systems in place to monitor infection control. Staffing levels did not meet best practice and national guidance. Records were not consistently completed and updated.

Medical and midwifery staff reported delays in recruitment processes trust-wide and this included anaesthetists. We found the birth to midwife ratio was 1:33; the national guidance was 1:28. We were informed that 13 midwife appointments had been made the previous week and would be in post by October 2014, which would bring the birth to midwife ratio down to a ratio of 1:31.

We found staff did not always check emergency equipment daily to ensure it was available in the event of an emergency situation.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure staff followed recognised national guidance. However we saw information in the external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were obese or morbidly obese, and one was overweight. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.

Staff were reported as kind and understanding. The service ensured women received accessible, individualised care, while respecting their needs and wishes.

The service was well-led at unit level and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service. Staff reported that they had several changes in managers in the last five years, with more changes planned in the near future. There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives.

An external review had been commissioned as there had been a cluster of eight serious incidents in a short space of time. Concerns previously raised in 2011 and 2012 had resulted in a number of actions; it was not clear how these actions had been monitored by the trust to ensure the service had acted on identified concerns and sustained improvements in practice.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

The unit was clean and well maintained. There were effective systems in place to monitor infection control.

Where incidents had been identified, staff had been made aware and action was taken. Between January 2013 and January 2014 there were eight reported serious incidents across the trust in women's services. We saw these related to the monitoring of care and treatment of women in early pregnancy, the antenatal period, labour and delivery.

Medical and midwifery staff reported delays in recruitment processes trust-wide and this included anaesthetists. We found the birth to midwife ratio was 1:33; the national guidance was 1:28. We were informed that 13 midwife appointments had been made the previous week and would be in post by October 2014, which would bring the birth to midwife ratio down to a ratio of 1:31.

Incidents

- Between January 2013 and January 2014 there were eight reported serious incidents across the trust in women's services. We saw these related to the monitoring of care and treatment of women in early pregnancy, the antenatal period, labour and delivery.
- A root cause analysis (RCA) is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again. A RCA had taken place in all cases, which highlighted lessons learnt and contributing factors. An action plan summary was shared with all staff, together with the completed and planned actions. Additionally, we saw information which showed staff received updates regarding guidelines, which had been introduced or changed to ensure staff were kept informed and patients received safe care. For example, we saw updated guidelines for antenatal screening for obesity.
- Staff stated they were encouraged to report incidents. We saw they received weekly patient safety bulletins, which were designed to rapidly disseminate learning from incidents or other concerns that had occurred within the trust. We also saw a newsletter, 'Maternity Measured' (Issue 1, June 2014) had recently been introduced. This also aimed to make positive changes by sharing information and learning from incidents and risks to improve patient safety and care.
- We saw information in the 'Maternity Measured' newsletter which indicated not all incidents had been logged on the incident reporting system. For example the newsletter highlights that the number of Postpartum Haemorrhages incidents was lower on the incident reporting system than those highlighted on the clinical records system. This may mean that not all incidents were being reported by the appropriate system. One of the eight serious incidents related to a woman who suffered a Postpartum Haemorrhage.
- Additionally, staff received a bi-monthly, lessons learnt from incidents in obstetrics and maternity feedback. We saw from the staff feedback from the 16 to 30 June 2014; there had been 117 reported incidents, with no moderate ones reported in this period. Information included when areas were short staffed /or there were a lack of suitably qualified trained staff and details of changes made from lessons learnt. Additionally, we were told, 'As a quick fix' and 'Short term' when the staff handovers took place if something became evident; it was added to the safety brief for staff.
- We also saw a newsletter; 'Maternity Measured' (Issue 1, June 2014) had recently been introduced. This also aimed to make positive changes by sharing information and learning from incidents and risks to improve patient safety and care.
- Multiprofessional perinatal mortality and morbidity meetings took place monthly. Midwifery and medical staff were encouraged to attend and the venue changed between the three sites to encourage attendance.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. Evidence provided by the trust showed 99% of venous thromboembolism (VTE) risk assessments had been carried out on all patients admitted to the women's inpatient facilities (the target rate for the trust was 95%).
- We saw between January and June 2014 the trust Safety Thermometer dashboard showed harm-free care in women's services.

Maternity and gynaecology

Cleanliness, infection control and hygiene

- We saw the trust had an infection control policy and evidence that it was reviewed. We saw most areas in the maternity unit were visibly clean and all staff reported they had infection control training. Trust policies were adhered to in relation to infection control; these included staff washing their hands, use of hand gel and bare below the elbow dress code.
- However, we found the décor in the delivery suite was dated. In the delivery rooms, there were areas of work surfaces that were chipped and that potentially could not be appropriately cleaned.
- Between April and June 2014, an audit was carried out each month for compliance on staff hand washing across women's services in Dewsbury, Pinderfields and Pontefract Hospitals. We saw they met their target of 98%.
- We saw in most of the areas we inspected that equipment had stickers on it with information showing it had been cleaned; this included portable electrical equipment.
- The trust integrated performance report dated May/ June 2014 reported no incidents of MRSA or Clostridium difficile infection between January and July 2014.
- We saw the noticeboard located outside the delivery suite showed there had not been any MRSA infections for four years in delivery, Clostridium difficile infection for 210+ days and staff were bare below the elbow 100% in July 2014.

Environment and equipment

- The environment in the maternity unit was secure. The delivery suite and ward were locked and required a call button entry for mothers and visitors and swipe card entry for staff.
- We saw that daily checks of equipment to ensure it was available for use in the delivery suite had not always been recorded. Staff told us this was because they did not always have time with the absence of sufficient midwives. When equipment had not been checked for several days, there were no mechanisms in place to alert senior staff, nor were any actions taken.
- In the delivery suite there were eight delivery rooms, one of which had been used for the birth pool. However, we were informed that because of the condition of the plumbing the pool could not be used.
- One delivery room was en-suite, the remaining had shared toilet and bathroom facilities. The delivery room with en-suite facilities was used as a delivery room and when needed as a bereavement room. There was not a dedicated bereavement room.
- We saw equipment was available to meet people's needs, such as Entonox, piped oxygen and cardiotocograph machines.
- We saw the resuscitation equipment was checked and cleaned. However, on several occasions the records showed the equipment had not consistently been checked daily. For example in the week prior to the inspection, we saw three of the resuscitaires we inspected had not been checked every day. Additionally two of them had been left two days between checks. This meant in the event of an emergency the appropriate equipment or medications may not be available to use or still be within their expiry date.

Medicines

- We inspected the medicines in the delivery suite and ward areas and found they were correct, appropriately stored with appropriate records kept.

Records

- We looked at 13 sets of care records. We found they were in paper format, comprehensive, up to date and in some areas of the unit they were of a very high standard of recording. We saw evidence that consent was obtained before procedures took place, such as before a women had a caesarean section. When not in use records were kept safe, in line with data protection.

Safeguarding

- The trust had a safeguarding lead who was also a midwife. They were employed to provide safeguarding training in both adults and children. We were told that training at safeguarding children level 3 had been given to all community midwives and the band 7 midwives across the service. This met with trust guidance and was in agreement with the local safeguarding children's board. We were told by staff each community midwife had eight hours safeguarding supervision each year; three group sessions all of which were face to face. These were all rostered in advance and monitored by the individual community managers
- Staff knew the procedure for reporting allegations or suspected incidents of abuse, including adults and children; they confirmed they had training.

Maternity and gynaecology

Mandatory training

- Staff told us they were up to date with mandatory training. This included attending annual cardiac and pulmonary resuscitation training and training specific to their role. The trust provided us with information about women's service training across the trust. Figures for 2014 showed 216 out of 279 staff had attended annual resuscitation training and 73 out of 90 had attended the three-yearly training. 100% of staff had received health and safety and safeguarding adults and children's training and 94.44% of staff had completed venous thromboembolism training.
- The trust had trainers in obstetric emergencies and the staff we spoke with confirmed they had training every year and involved all members of the multi-professional team. An example of obstetric emergency training included cord prolapse.
- Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and support.

Assessing and responding to patient risk

- The unit used the Modified Obstetric Early Warning Scoring system to manage deteriorating patients. We saw in the records we looked at that the documentation had been completed and escalated appropriately.
- We noted the trust did not have a similar scoring system for managing the high-risk newborn infant within the postnatal ward setting. When questioned, midwives within the postnatal ward were unaware of the Newborn Track and Trigger System.
- We saw information in the external review of midwifery services from May 2014 in the cases they reviewed they found risk management during the antenatal period and in labour were below standard, which may have contributed to the poor outcomes. There were also instances where junior medical staff had made decisions without senior obstetric input.

Midwifery staffing

- The executive summary of the meeting of the trust executive board (June 2014) showed they discussed safe staffing levels and what they needed to achieve to ensure compliance with the new guidance 'How to ensure the right people, with the right skills, are in the right place at the right time' (NHS Quality Board, November 2013). This included using evidence-based tools to describe staff capacity and capability and submitting a report to be discussed at the trust board every six months. The board report would contain details of reviews and actions taken to meet the recent guidance, including updates on 'Actual staff versus planned staffing levels shift by shift; impact on quality and safety; reasons for shortfalls, impact and action taken'. Safe staffing levels were also reported on the trust's corporate risk register.
- The midwife to mother ratio across the midwifery service was published at 1:33, the national guidance being 1:28. Evidence shows that achieving a 1:28 ratio ensures a midwifery service will be able to provide 1-1 care in labour to mothers and meet the dependencies of all mothers; accessing care in pregnancy, childbirth and the postnatal period. When the ratio of 1:28 midwife to mothers is not achieved services risk not being able to provide safe and appropriate care to women. Staff were aware 13 midwife appointments had been made the previous week and there were further plans to address shortfalls with funding having been approved to recruit five more midwives.
- Staff in each area we inspected were aware of the safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed roster. They reported cross-department/site team working to address staff shortfalls when needed. Information provided by the trust relating to incident reporting and lessons learned showed there had been 32 incidents of 'short staffing/insufficient suitably qualified staff' between 1 and 13 June 2014.
- On the antenatal/postnatal ward we were told four staff were on maternity leave and although the trust was aware of this in advance, the posts had not been filled; leaving the ward understaffed on establishment figures.
- Cross-site working or agency staff were used when needed, but figures showed the shifts were not always filled. For example, on 17 July 2014 the daily nursing staff assessment and plan showed minimum safe staffing levels on delivery suite nights should have been a coordinator, four midwives, two healthcare assistants and a scrub nurse. Although the record showed there was an extra healthcare assistant, they were a midwife and scrub nurse down. On the antenatal/postnatal ward, the plan showed there was an extra healthcare assistant to the minimum safe staffing level figures. However, they were one midwife down and although an agency midwife had been requested the shift was not filled.

Maternity and gynaecology

- We found the transitional care unit (based on the antenatal/postnatal ward) was led by a nursery nurse with input from one of the midwives on duty. There was no neonatal nurse, but paediatricians visited the unit each day and good liaison was said to exist between the ward, neonatal unit and neonatal outreach team. A weekly meeting was held, however we were told because communication was good the meetings now take place fortnightly.
- On the day of inspection, we saw on the noticeboard outside the delivery suite that the staffing levels were recorded at between 81.6% and 92.3% of what they should be. In addition, we were told the staffing vacancies on this ward were 23% (−2.49 WTE midwives)
- We were told by staff that the current maternity leave on the antenatal/postnatal ward was 28% and that sickness leave on the delivery suite was 11%.
- Ratio of supervisors of midwives was 1:18, the national guidance being 1:15. We were informed there were four midwives in training to be supervisors and this would bring the ratio to the expected level.
- The antenatal and newborn screening coordinator told us the quality assurance visit from National Screening is due to take place in November 2014. The head of midwifery had agreed funding for a 0.8 WTE, band 7 until November to help prepare for the visit. We were told the post was new, but it would come from existing staffing within the trust. There were concerns from staff this could have an impact on already struggling teams on wards and in clinics.

Medical staffing

- Consultants obstetricians provided cover on this site for delivery suite, in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance. This involved being present between 9am to 8pm, Monday to Friday Saturday and Sunday cover was 3 hours per day (on site) and on call out of hours.
- Junior doctors told us out-of-hours consultants were very easily contactable. Staff were managing the unit well and they had no concerns with patient safety. We were told by the doctors that team working was good.
- We were told by the doctors that all consultants took a daily ward round and saw all the admitted women.
- The trust risk register identified a risk due to the numbers of vacancies in anaesthetic junior rotas. It stated there was a clinical risk associated with the provision of suitably qualified and graded anaesthetists to support the obstetric and theatre rotas. In the interim locums had been used and consultants worked extra shifts. There was a workforce plan in place to reach establishment of more doctors and lessen the use of locum doctors.
- Medical and midwifery staff reported delays in recruitment processes trust-wide. All requests for the recruitment panel were presented monthly, but these meetings were cancelled or applications were sent back for clarification leading to significant delays in filling staff vacancies

Nursing and medical handover

- The Situation, Background, Assessment, Recommendation transfer record was used when handing over care between staff. This included the use of it by managers to assess the shortfalls in staffing and how they were addressed. The tool was used in maternity services where there may be multiple handovers between staff and it assisted in improving communication.
- We were informed that each morning (Monday to Friday) midwifery managers on all three sites communicated and documented staffing and capacity issues across the service. This assisted with staffing of all clinical areas and where appropriate staff were moved between sites to assist in meeting dependency demands.
- We were told by doctors that there were daily consultant-led ward rounds and consultants provided hands-on care.

Major incident awareness and training

- The trust had a major incident plan. This detailed the action staff should take in dealing with a major incident.
- We saw that a live obstetric drill in delivery had taken place in May 2014 and was undertaken by the consultant for obstetrics and gynaecology. We saw recommendations from the drill had been made and changes requested in the way handover took place on delivery and to help organise the team better in the event of an emergency.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure staff followed recognised national guidance. However we saw information in the external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were obese or morbidly obese, and one was overweight. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.

The service had weekly information updates, which informed staff about new guidance to ensure they were up to date with best practice.

The trust and community service had achieved the baby friendly, UNICEF Award Level 3. 25 new breastfeeding champions had been identified and peer support training had commenced (July 2014) and supported breast feeding in these areas. Breast feeding figures provided by the trust showed that whilst they were not meeting national targets but there was an upward trend of mother's breast feeding at delivery

Multidisciplinary working took place across the trust and encouraged an integrated approach to the services provided. There was a Maternity Service Liaison Committee (MSLC). The group discussed maternity provision across the trust and included service managers, providers and funders, as well as local representatives from children's and parent services.

Evidence-based care and treatment

- The maternity unit used their own guidelines across all sites based on a combination of NICE and Royal College of Obstetricians and Gynaecologists guidelines (such as 'Safer Childbirth: minimum standards for the organisation and delivery of care in labour').
- We saw the use of the National Early Warning Score to monitor deteriorating patients in the records we looked at and the documentation had been completed correctly.
- The service had weekly information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- We saw information in the external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were obese or morbidly obese, and one was overweight. The risks to the morbidly obese pregnant woman are considerable, and include pre-eclampsia, venous thromboembolism and anaesthetic complications. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.

Pain relief

- People we spoke with told us they received pain relief of their choice and this included epidural anaesthetic (available 24 hours a day), Entonox, TENS therapy and opiates.

Breastfeeding

- Breast feeding figures provided by the trust showed that whilst they were not meeting national targets but there was an upward trend of mother's breast feeding at delivery. Between April and June 2014 figures showed 56.3% to 60.3% of mothers were breastfeeding at delivery. The national target was 75%. The trust had an action plan as to how they would address the shortfalls.
- The trust and community service had achieved the baby friendly, UNICEF Award Level 3.25 new breastfeeding champions had been identified and peer support training had commenced (July 2014) and supported breast feeding in these areas.

Patient outcomes

- Between June 2013 and May 2014 the total number of births at Dewsbury maternity unit was: 2374. Of these births there were 232 (9.8%) elective caesarean sections and 334 (14.1%) emergency caesarean sections, which was in line with the national averages.
- There had been three neonatal deaths between June 2013 and May 2014.
- The latest published Local Supervising Authority Report for Midwifery Supervision for Yorkshire and Humber gave a stillbirth rate for Mid Yorkshire Hospitals of 5.9% against the national rate of 4.8%
- The maternity service had eight serious incidents since January 2013, with six occurring between November 2013 and January 2014. In addition to an internal inquiry, an external review was commissioned. The

service had been proactive in reviewing its practices and guidelines ahead of the external review and changes had been made where the need for improvements had already been identified.

Multidisciplinary working

- Multidisciplinary working took place across the trust and encouraged an integrated approach to the services provided.
- We saw clinical governance meetings took place and people who were involved in those meetings included consultants in obstetrics, gynaecology, urology and midwifery, clinical governance midwife, governance midwife and audit facilitators. Areas discussed included complaints and serious incidents.
- There was a Maternity Service Liaison Committee. The group discussed maternity provision across the trust and included service managers, providers and funders, as well as local representatives from children's and parent services.
- Antenatal clinics were also attended by specialist midwives such as the drug liaison midwife, and the young women's midwife and clinicians. There was a weekly joint diabetes clinic with a consultant endocrinologist, providing care and support for pregnant women with diabetes.
- Staff reported that midwives and doctors worked closely and the consultant staff were very approachable.
- We spoke with a police officer in relation to keeping people safe. They spoke positively about the police relationship with the trust in protecting people from harm.

Seven-day services

- Consultant obstetricians provided cover Monday to Friday between 9am and 8pm (11 hours a day). On Saturday and Sunday cover was three hours a day (on-site). This complied with Royal College of Obstetricians and Gynaecologists guidelines.
- A team of specialist registrars and junior doctors contributed to a rota to provide on-site medical cover for each 24-hour period.
- Midwives, nurses and support staff were also rostered to provide a 24-hour, seven day a week service on the delivery suite, maternity theatres and the antenatal/ postnatal ward. Band 7 midwives were on duty every shift as labour ward coordinators on the delivery suite. Staffing levels did not support rostering the agreed numbers of midwives on the ward for each shift. There were insufficient scrub nurses to cover the roster in theatre so midwives undertook this role when a nurse was not on duty. Staff reported that this had an impact on staffing levels on the delivery suite because two midwives were often in theatre, putting pressure on the service. At the time of inspection, two scrub nurses were in the process of being recruited.
- We found the service had access to pharmacy services when needed.
- An on-call consultant anaesthetist was available 24 hours a day, seven days a week.

Are maternity and gynaecology services caring?

Good

Dewsbury maternity services provided compassionate individualised care to people visiting the service and people were treated with privacy, dignity and respect. We saw letters and cards of appreciation and positive comments about people's experience of the unit.

The trust used a national survey to find out about the experiences of people who received care and treatment. The National Patient Survey 2013 showed positive responses for partners being involved in labour. Midwives had received bereavement training and the trust was advertising to appoint a midwife specialised in this area.

The trust had a community midwife who had developed advanced skills in listening and worked in a specialist role offering support to women with mental health issues. The midwife was trained in cognitive behaviour therapy. We were told that all staff had received bereavement training and the trust was advertising to appoint a midwife specialised in this area

Compassionate care

- We found within the delivery suite that birth partners were encouraged to accompany women to provide support during labour and delivery.
- Women received one to one care and support in labour 98% of the time.

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- We observed women being treated with compassion, dignity and respect. However, in the delivery suite we saw doors to rooms were not always closed when people were receiving care and there was no signage to show when rooms were occupied.
- We saw letters/cards of appreciation and positive comments about people's experience of the unit.
- The friends and family test had been introduced over the last few months and for the delivery suite 98% of women recommended the service.
- The trust used a national survey to find out about the experiences of people who received care and treatment. During summer 2013, a questionnaire was sent to all women who gave birth in February 2013, and 195 responses were received. People were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question (the higher the score, the better). Each trust also received a rating of 'Better', 'About the same' or 'Worse'. For being involved enough in decisions about their care during labour and birth, The Mid Yorkshire Hospitals NHS Trust scored 9 out of 10 (average compared with other trusts). For feeling they were treated with kindness and understanding by staff after the birth, the trust scored 8 out of 10 (above average compared with other trusts).
- The trust survey 2013 stated 95% of women confirmed, when they were in labour, their partner or someone else close to them was involved in their care as much as they wanted.
- Staff reported they were not aware of any complaints received relating to long theatre waits, and no concerns had come from the Friends and Family Test (FFT)'s (NHS friends and family test is feedback on the care and treatment you receive.) We spoke with two women who had delivered by elective caesarean section the previous day. They told us they did not have a delay in going to theatre and their experience was positive.

Patient understanding and involvement

- Women we spoke with stated they had been involved in decisions regarding their choice of birth and were informed of the risks and benefits of each. They also told us they felt involved in their care and supported by staff.
- In the national survey in 2013, for people being involved enough in decisions about their care during labour and birth, the trust scored 9 out of 10 (average compared with other trusts).

Emotional support

- The trust had a community midwife who had developed advanced skills in listening and worked in a specialist role offering support to women with mental health issues. They were trained in cognitive behaviour therapy. A pre-conceptual, pregnancy and postnatal service was offered to women with anxiety- and stress-related conditions. An example was given where a mother with a needle phobia was seen and successfully counselled before pregnancy. By the time she was using maternity services, she was able to have blood tests performed. This was an example of where midwives have been supported in developing an innovation in midwifery practices that benefited mothers.
- We were told that all staff had received bereavement training and the trust was advertising to appoint a midwife specialised in this area.
- The transitional care unit (on the antenatal/postnatal ward) had recently opened. We spoke with two mothers and one partner on this unit. One person told us all staff were kind and they were well looked after. They were happy that, although their baby had to be nursed in an incubator and needed more individualised care from staff, their baby was able to stay with them. Another person told us they had no complaints; they had received, "Excellent care."
- The delivery room used for mothers whose baby had died was also used at busy times for women in labour. The posters and equipment in this room made the environment unsuitable for grieving mothers.
- Written information about bereavement services and support was available. The information could be provided in different languages on request. We were also told translation services would be arranged when needed.
- A chapel and Muslim prayer room were available in the hospital for people to use.

Are maternity and gynaecology services responsive?

Good

The service was responsive and ensured women received accessible, individual care while respecting their needs and wishes. Staff rotated between Pinderfields and Dewsbury

maternity units. This ensured they had the knowledge and skills to work in different areas/locations if they were needed. Staff also worked flexibly between units when there were staff shortages.

We saw multidisciplinary working to meet the needs of patient groups in relation to a young women's team of midwives to support women under the age of 19.

A reconfiguration of women's and children's services was due to be completed 2016 and would provide a service to meet the needs of the local population. When concerns or complaints had been identified, they were dealt with quickly and changes made, if appropriate.

We saw there was a complaints leaflet and clear instructions on how to make a complaint or express appreciation. The information included what to do if people were not happy with the response from the trust, and how to contact the Patient Advice and Liaison Service.

Service planning and delivery to meet the needs of local people

- The trust had an escalation policy to deal with busy times and staff shortages. Staff worked flexibly across the trust to meet the shortages and service needs. Thirteen midwives had been appointed to address staffing shortfalls and we were told these would be in place by October 2014.
- Dewsbury is to be developed as a midwife-led unit, with all women booked for consultant-led care attending Pinderfields Hospital from 2016. Little upgrading or development of existing service provision is planned in the interim, leaving the environment dated and showing signs of wear in places.
- Staff did not always feel involved in the decisions made about future service provision. We were told of examples where the planned reconfiguration had limited clinical engagement and staff ideas on necessary changes to plans were not listened to.

Access and flow

- With the exception of midwifery managers and obstetric consultant's staff rotated between Dewsbury and Pinderfields Maternity Units. This ensured they had the knowledge and skills to work in different areas/locations should they be needed. Staff also worked flexible between units when there were staff shortages. Staff told us the flexibility was working well. They initially were concerned about working at other sites and now found they didn't mind and had found it beneficial to their practice.
- One of the consultant anaesthetists at the trust had recently researched the effects of early discharge on mothers who had received an elective caesarean section. They had written a paper 'Advanced recovery in Obstetrics' and as a result had provided guidance about discharging postnatal patients in good health, within 24 hours of delivery instead of the average three to four days; providing a good outcome for the mother. We were told by the postnatal ward staff the guidance had recently been introduced. Two patients told us their babies were not their first child and they were pleased they did not have to stay in hospital following their caesarean section.
- Caesarean sections were scheduled every day, but there was no specified time of surgery because this was undertaken by the doctors on duty on the delivery suite. The time of operation depended on how busy the unit was; if the unit was busy, women who had been admitted for caesarean section were delayed. Staff told us delays frequently occurred, with women not being operated on until late afternoon. This could mean women being without food or drink for over 12 hours.
- Inductions of labour took place on the antenatal/ postnatal ward and once in labour women were transferred to the delivery suite. Women for induction were cared for in a five-bedded antenatal ward. Staff told us that sometimes women did deliver in the ward, but when this occurred ("No more than 10 times per year") the other women were moved elsewhere.

Meeting people's individual needs

In meeting people's individual needs specialist leads/ services were provided by the trust and included:

- A Young Women's, midwifery team of three midwives, offering an enhanced service to approximately 70 selected people under 19 years of age, in pregnancy and following birth.
- 'Active Birth Classes' were also provided to promote normal birth.

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- An antenatal and newborn screening co-ordinator was employed across the service and with sole responsibility for the organisation, delivery and audit of all antenatal and newborn screening programmes for approximately 7000 women.
- Translation facilities were available; information leaflets were available in different languages.

Learning from complaints and concerns

- We saw there was a complaints leaflet and clear instructions on how to make a complaint or express appreciation. The information included what to do if people were not happy with the response from the trust, and how to contact the Patient Advice and Liaison Service .
- There had been seven complaints between March and May 2014. We saw concerns and complaints were listened to and investigated within three days; meeting the 100% trust target. Outcomes of investigations, lessons learned and changes to practice were disseminated to staff in the form of bulletins, newsletters, meeting and emails.
- Staff demonstrated the complaints process and their active involvement with women and their families. Personal contact would be made by a senior midwife and, when possible, arrangements made to meet with the complainant. Since this new trust-wide approach had been adopted, staff reported a more positive response from the few mothers/families who had complained.

Are maternity and gynaecology services well-led?

Requires improvement

In March 2014 women's services were placed into one directorate and they had a clear strategy and vision for the changes that were to take place over the next few years. We found the service was well-led at unit level and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service. However, there were mixed messages about how open the culture was within the leadership team and staff sometimes felt senior managers were not always visible.

An external review had been commissioned as there had been a cluster of serious incidents in a short space of time. Concerns previously raised in 2011 and 2012 had resulted in a number of actions; it was not clear how these actions had been monitored by the trust to ensure the service had acted on identified concerns and sustained improvements in practice.

The midwife to mother's ratios were above national guidance at one midwife to 33 mothers. The trust was aiming to improve this with recruitment to one midwife to 31 mothers' national guidance states this ratio should be one to 28. Community midwives were also working outside of national guidance of one midwife to 100 mothers. When the midwife to mothers ratios are not achieved services risk not being able to provide safe and appropriate care to women. We were unable to establish the rationale from the trust as to why the service was not aiming to achieve best practice in relation to national guidance.

Staff reported that they had several changes in managers in the last five years, with more changes planned in the near future. There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives. There were fewer midwifery management positions above band 7 than would have been expected for a service of this size, leading to additional responsibility being placed on senior clinical staff.

Vision and strategy for this service

- The women's service had a strategy and vision for the future of service provision in Wakefield, Dewsbury and Pontefract. A reconfiguration of women's and children's services was due for completion in 2016. Dewsbury District Hospital will become a midwife-led unit; Pinderfields District Hospital will become a consultant/ midwife-led unit and Pontefract General Hospital will remain a midwife-led unit. The reconfiguration was in progress after previous consultation with commissioners and other interested parties such as families and members of staff.

Governance, risk management and quality measurement

- We saw information in the Quality Committee minutes (14 February 2014), which stated an external review of the serious incidents in maternity had been commissioned as there had been a cluster of serious incidents in a short space of time. Depending on the

findings of the review the investigators would look at action plans from a previous review carried out in 2011 and the CQC report in 2012, which also raised concerns. The director of nursing confirmed action plans from these had been delivered at the time but there may be an issue with actions not being sustained. It was not clear how these actions were monitored by the trust to ensure the service had acted on concerns and sustained safe practices.

- We looked at the report of the external review of maternity services in May 2014. The objectives of the review indicated the investigators would investigate whether recommendations made by the 2011 review of maternity services had been successfully implemented and had improved practice. We could not see any information in the report which indicated whether the trust had acted on the recommendations from the previous review. This meant the service could not demonstrate they learned from incidents and changed practices to ensure patients received safe care.
- The external review of maternity services 2014 highlighted that the trust must be assured that there was a robust system for the review, development and writing of clinical guidelines based on the most up to date available evidence. For example at the time of the serious incidents the obesity guideline was out of date, and did not reflect national standards. It had since been amended, and approved by the trust.
- The review also found the investigations of the serious incidents did not always identify the root cause and specific learning points were not always identified in the learning points.
- The governance committee for the maternity service met monthly. We looked at the minutes for May 2014 and saw agenda items covered areas such as accidents, access to appointments, admission, transfer and discharge. We saw actions taken to address shortfalls and lessons learned.
- The midwife to mother's ratios were above national guidance at one midwife to 33 mothers. The trust was aiming to improve this with recruitment to one midwife to 31 mothers' national guidance states this ratio should be one to 28. Community midwives were also working outside of national guidance of one midwife to 100 mothers. When the midwife to mothers ratios are not achieved services risk not being able to provide safe and appropriate care to women. We were unable to establish the rationale from the trust as to why the service was not aiming to achieve best practice in relation to national guidance.
- The women's quality and performance meeting occurred monthly. We looked at the minutes for April 2014. We saw heads of wards and department were included in the meeting and were updated on management changes across the trust. This included the appointment of an interim Director of Clinical Services for Women's & Children's, who would be in post by May 2014. Other areas of discussion included the recruitment process, consultant updates and staffing.The trust had a risk register identifying areas of concern, actions and timescales of implementation.
- Team leaders demonstrated awareness of governance arrangements. They detailed actions taken to monitor patient safety and risk. Staff were aware of their responsibility to report incidents. Root cause analysis into serious incidents occurred and provided learning points for staff. For example, in the case with postpartum haemorrhage, analysis found assistance was not sought early enough on recognition of a heavy bleed. The recommendations were to use a pro-forma to aid clinical consistency and act as an aid memoire to promote clear documentation and instructions. We saw evidence the proforma had been used as recommended in records we inspected.

Leadership of service

- There was a clear leadership structure within the service from Chief Executive to ward level. The leadership team had clear ambitions for the success of the reconfiguration of women's services within Dewsbury and Wakefield.
- There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives. There were fewer midwifery management positions above band 7 than would have been expected for a service of this size, leading to additional responsibility being placed on senior clinical staff.
- Staff reported that they had several changes in manager in the last five years, with more changes planned in the near future. The change in the head of midwifery had been sudden, but staff expressed optimism for the future with this move and had already seen positive changes.

- Staff reported seeing their line managers regularly, but stated the trust executive team were not visible at clinical level.
- Staff reported feeling 'dismissed' and seen as 'little people' by senior managers making them feel undervalued.

Culture within the service

- Staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service.
- We could not fully establish how open the culture was within the leadership team, because we had mixed messages of their openness from staff. Some staff told us they felt listened to and supported by their line managers. Staff told us the new head of midwifery was very supportive and staff were hopeful the previous unsupportive culture would change. The staff survey showed staff felt underappreciated and morale was low. Staff told us local leadership was good.
- Staff told us they could raise concerns and they felt their concerns would be dealt with appropriately and this included whistleblowing. Other staff told us, in relation to incidents and feedback, the "No blame culture could be better."

Public and staff engagement

- At a meeting of the West Yorkshire Combined Authority, a service that gives people a chance to give their views on proposals to reconfigure hospital services. people expressed their views of needing a convenient, reliable way of travelling between the trust's three hospital sites. As a result of that meeting, a free bus service for patients and visitors was set up.
- There was a Maternity Service Liaison Committee. The group discussed maternity provision across the trust and included service managers, providers and funders, as well as local representatives from children's and parent services.
- We saw staff received a 'MY Bulletin' and were kept up to date with guidance, changes to practice and updates of information within the trust. We saw the bulletin referred to the Pulse check and reminded staff to complete the staff questionnaire to provide a snapshot of how they were feeling at a given moment in time.

Innovation, improvement and sustainability

- Building on the success of an existing community group set up by local women in Dewsbury called Aunty Pam's, joint working with the midwifery service has been established. It offered advice on pregnancy and childbirth at their drop-in centre or via their website. Formally 'hard to reach women' were now accessing antenatal care and making informed choices. Through this community project the first Asian mother had been supported in her choice of a planned home birth. Joint work between Aunty Pam's, midwives and Bradford University were also taking place relating to translation services. Additionally, Aunty Pam's community group hosted and chaired the Dewsbury Maternity Services Liaison Committee.
- A Teenage Pregnancy Service was available for people under 19years of age. We saw from the clinical practice care pathway relating to this service, they followed NICE guidance. The role was introduced as a flexible, accessible service to support vulnerable young women in conjunction with other health providers and other external support services across the trust.
- Baby Friendly UNICEF Award Level three had been achieved across the trust and community service. The award is based on evidence-based standards, designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.
- One of the ward managers had developed a 'Glimpses of Brilliance' list, in which they collated positive comments received through the friends and family test and compliments given by mothers in letters or thank you cards. The list was available in clinical areas for staff and visitors to see and enables the sharing of positive comments with the wider team.
- Consultant midwives for normality and public health were in post. However, the consultant for normality was currently working as the interim head of midwifery.

Services for children and young people

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

Information about the service

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

Currently, in Dewsbury Hospital, ward children's seven included 18 beds for inpatient stays and child assessment. There was also an area in a different part of the hospital that provided elective day case minor surgery beds for a small number of children, which opened on selected days of the week. The hospital also had a special care baby unit (SCBU), which accepted up to eight babies at level three special care dependency levels. Ward seven will soon close (August 2014) and a newly built eight-bed child assessment unit will open adjacent to the emergency department.

The trust reported that it had 7090 inpatient attendances, 4886 new outpatient attendances and 8945 outpatient follow-up attendances for paediatric services across all locations over the last 12 months.

During our inspection of Dewsbury Hospital we visited ward seven, the SCBU and the children's centre (outpatient department). At both hospitals we talked with five medical staff and 27 nursing and allied healthcare professionals, and examined 15 medical/nursing records.

Services for children and young people

Summary of findings

We rated the safety and responsiveness of children's services as requires improvement. We found that care was good; children's services were effective and were well led

We found all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. There were incident reporting mechanisms in place. At ward and unit level risks were regularly assessed and monitored, with control measures in place. However, we found there was confusion over version control on risk registers.

We found ward seven was staffed sufficiently to meet the needs of children and families. However, staffing of the children's outpatient department was not satisfactory because there was not always a readily available registered children's nurse to oversee the clinics and staff were not aware of any protocol to adequately access staffing, advice and support when needed.

Children, young people and parents told us they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to their treatment and care.

The trust was in the process of reconfiguring inpatient services at Dewsbury and Pinderfields Hospitals, which met national guidelines for the centralisation of children's inpatient services. During our review we found there was a lack of clarity on the potential responsiveness of service delivery after implementation of the change, which was to take place shortly. The service did not currently have formal arrangements in place to respond to the transitional needs of adolescents moving to adult services, except for children with diabetes.

We found that children's services were well led at ward and unit level with governance processes in place. There were governance processes in place. There was a culture of openness and flexibility at ward and unit level that placed the child and family at the centre of decision-making processes. However, there was no nominated executive and non-executive director at board level to champion children's rights.The Chief Nurse was the nominated safeguarding children lead.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms. There was some confusion about the services risk register because we were provided with four different versions before receiving a fifth version, and the service was not clear which was the correct version. At ward/unit level we found risks were regularly assessed and monitored, and control measures put in place.

We found all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. We found the environment on ward seven was colourful, warm and welcoming for children and families. Medicines were stored and administered correctly. Medical records were handled safely and protected. Staff demonstrated awareness of the laws surrounding children and young people's consent. Staff had received a range of mandatory training and were aware of how to safeguard children.

We found a mixed picture regarding staffing within all clinical areas of the inpatient children's services. We found ward seven was staffed sufficiently to meet the needs of children and families. Staffing of the children's outpatient departments (including Dewsbury, Pinderfields and Pontefract) was not satisfactory because there was not always a readily available registered children's nurse to oversee the clinics and staff were not aware of any protocol to adequately access staffing, advice and support when needed. Concerns were raised about the staffing of some spans of duty on the SCBU.

Incidents

- Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms. The ward manager felt their staff were good at reporting incidents. We were told incident reports at Dewsbury Hospital were very low and that any that were reported were discussed in the staff meeting held monthly. We reviewed a sample of these meeting minutes and saw incidents were discussed.
- In addition, staff were able to complete a paediatric clinical events report form, which complemented the incident reporting processes. We saw that these allowed clinically focused reviews about aspects of a child's care. For example, we saw one form that reviewed a resuscitation event noted how the event had progressed and how learning may occur. The ward manager (ward seven) explained that these were discussed in periodic meetings with members of staff to share learning.
- The integrated children and family services (hospital and community children's services) governance committee meeting minutes included a standing agenda item for the discussion of incidents.
- We reviewed submitted incident data for the children's inpatient areas for Pinderfields and Dewsbury hospitals for the period July 2013 to June 2014. A total of 89 incident reports had been recorded and had been rated as either low level or no harm in relation to the severity of the incident. There were no particular themes associated with the data with the exception of 20 incidents that were linked to medications. The head of clinical service along with the group manager explained how work had been completed to adequately support staff with these types of errors.

Cleanliness, infection control and hygiene

- We found ward seven, the children's outpatient department and SCBU were kept very clean, tidy and had various infection prevention measures in place, such as electronic wall-mounted hand gels and hand wash sinks available.
- We observed members of medical, nursing and other staff regularly performing hand hygiene on ward seven.
- We were told that regular hand hygiene audits and infection control audits were undertaken, and we reviewed completed examples. The SCBU showed evidence of regular cleaning checks and other audits.
- Each area in the service had nominated members of nursing staff who acted as infection control link nurses who would share information at staff meetings and ensured staff maintained correct infection control procedures.

Environment and equipment

- We found the environment on ward seven was well maintained. The environment was colourful and had a warm and welcoming atmosphere. The ward was organised into two areas. One part was the overnight inpatient area; the other area accommodated the child assessment unit. Both areas were openly accessible and we saw the staff worked closely together.

Services for children and young people

- The SCBU at Dewsbury was spacious, clean and well maintained.
- Staff told us and we saw that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. We saw records that showed the trust's medical physics department regularly tested and serviced equipment.

Medicines

- We found medicines had been appropriately stored, checked and administered in the clinical areas where children received inpatient care.
- We reviewed a sample of governance meeting minutes for children's services and saw medicines management was a standing agenda item and involved regular discussion about areas such as medications training and audit feedback. Discussions included areas for action (where identified) and were followed up in subsequent meetings.
- The risk register for children's services included "failure to prescribe and administer medication correctly to children and families". The register included a range of measures and controls to ensure the risk would be actively managed.

Records

- The ward had a ward clerk who carefully managed clinical records. We found records were stored securely during our inspection.
- We found medical records had been appropriately completed by the respective paediatricians and surgeons. Nursing documentation included an assessment of the child/young person's activities of daily living along with a family-centred care plan that had been individualised where needed to reflect the child and family's needs. Detailed progress records had been maintained by nurses for each span of duty.
- The children's service used an early warning system developed regionally to detect a sick child or infant who may require urgent/critical care. The system, known as the paediatric advanced warning score (PAWS), allowed the paediatrician and children's nursing team to promptly identify when a child's clinical observations may be outside the normal range. The colour codes on the charts assist the decision-making processes on stabilisation and transfer of critically ill children to a regional Paediatric Intensive Care Unit using clinical guidelines. We reviewed a sample of PAWS observation charts and found these were completed in detail by members of the nursing team.

Consent

- Most elective and all emergency surgery for children was undertaken at Pinderfields Hospital. We were told some day surgery sessions were held at Dewsbury, although none were being held during our inspection. The hospital did not hold pre-assessment clinics for elective surgery at Pinderfields, which meant consent was most commonly recorded on the morning of surgery. This may mean the parent and child (who can understand the proposed surgery) may not always have sufficient time to weigh up the benefits and risks of surgery. However, parents on the day surgery told us they had received information about the surgery before signing the consent form.
- Staff we talked with showed that they understood the Gillick competency standard surrounding consent for children. Staff explained the consent process completed by surgeons actively encouraged the involvement of young people in decisions relating to their proposed treatment.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arises.
- The safeguarding policy linked with the 'West Yorkshire consortium procedures manual', which was available online. The trust's safeguarding policy included clear guidance about the level of safeguarding required by different staff groups. Permanent clinical staff should be trained to level-three standard.
- Initial training records submitted by the trust showed 90% of staff within the women's and children's division had received level-three training, although the record did not make it clear where these staff groups worked within the division.
- Training records held locally by each ward/department manager showed high levels of attendance. For example, the training record for ward seven showed 100% of staff working on the ward had received level-three safeguarding training within the trust's expected timespan of every three years.

Services for children and young people

Mandatory training

- Members of staff of all grades confirmed they received a range of mandatory training. Uptake of training was carefully managed by the band seven ward manager (ward seven) and four band six sisters who acted as team leaders for groups of staff. The team leaders monitored training and ensured staff completed training.
- We reviewed the training record for ward seven, which showed good levels of compliance. For example, medicines management training and PILS (paediatric immediate life support) was currently 91% of staff attending and other training such as blood transfusion collection stood at 100%.

Assessing and responding to patient risk

- Before the inspection we requested risk registers at trust level and service level. The trust submitted four different risk registers relating to children's acute inpatient services, all of which carried a different title. Risk registers included 'children & family service risk register', 'paediatrics risk register', 'women's & children's 25th June 2014' and 'women's & children's risk register scores 11+, 9 July 2014'.
- Few of these risk registers captured the same risks recorded for the acute inpatient children's services. This meant the risk registers may not be accurate and different versions would make it difficult to manage individual risks. During an interview with the head of clinical service and group manager we showed them the four risk registers, which caused some confusion because none of these risk registers were the risk register that the management team were familiar with.
- The management team later forwarded a fifth version of the risk register, which captured current risks for children's services. We reviewed the risks and saw none were currently identified as a major risk, although some were rated at a moderate risk. The risks identified had measures in place to manage the risk appropriately.
- At a local level the children's service managed local clinical and environmental risks appropriately. For example, ward seven had completed local risk assessments regarding the clinical matters and the environment. The ward manager also explained and showed examples of how individual child- and family-focused risk assessments had been completed. These were discussed at multidisciplinary meetings when needed.

Nursing staffing

- We did not identify any concerns regarding the staffing levels on ward seven when compared with beds available and bed occupancy. Expected staffing of the current ward was four registered children's nurses and two healthcare assistants during the day and three registered children's nurses at night. Staff we talked with on ward seven confirmed they felt the ward was adequately staffed so that the needs of children and families could be met.
- The ward manager explained some vacancies had been kept open because of the reconfiguration due to take place. We were told the majority of staff would continue to work on the new child assessment unit when ward seven closes and four other staff would be redeployed to Pinderfields Hospital to work on their child assessment unit and gate 46.
- We did not identify any concerns over the current staffing arrangements on the SCBU. There were a minimum of two registered nurses available on each shift to care for a maximum of eight special care (level-three dependency) babies. This met the minimum staffing requirements of the nationally recognised British Association of Perinatal Medicine staffing standards, which require one nurse for every four special care babies.
- However, the minimum staffing agreed for the SCBU unit at Dewsbury Hospital also included one healthcare assistant in addition to the two registered nurses for each span of duty. We were told via a whistleblowing alert that the healthcare assistant on duty had been taken on some shifts to work at the Pinderfields' neonatal unit. This meant staffing had fallen below the trust's minimum requirements defined for the SCBU at Dewsbury Hospital and we were told this made it difficult for members of staff to take breaks and perform other duties. We were told of 15 spans of duty (out of 42) during June and July when staffing did not meet requirements. We were not able to corroborate the alert because we had completed our inspection when we received it. The SCBUs at Dewsbury and Pinderfields were managed together and we have highlighted other staffing matters concerning the neonatal/SCBU unit at Pinderfields Hospital in the location report for that hospital.The trust told us that staffing of SCBU was managed trust wide rather than for each hospital and that backup staffing was provided from the children's ward when required.

Services for children and young people

- The outpatient departments at Pinderfields, Dewsbury and Pontefract Hospitals were managed and run as one service. Normal staffing of the departments included three staff nurses (one for each department in Dewsbury, Pinderfields and Pontefract) along with one healthcare assistant and one healthcare assistant working 22.5 hours on a three-month secondment. There was a fourth staff nurse who was currently on long-term leave. We were concerned that the children's outpatient departments had no flexibility in staffing, which may lead to inadequate cover at times.
- For example, on 17 July 2014, the three outpatient departments in each location were inadequately staffed. In the morning at Dewsbury there were three paediatric clinics in progress and these were being managed by one healthcare assistant and no registered children's nurse. In Pinderfields Hospital in the afternoon three paediatric clinics were being managed by a healthcare assistant and no registered children's nurse. The only registered children's nurse on duty in the outpatient setting across locations was based in Pontefract.
- It was not clear how the two healthcare assistants were provided with adequate oversight by the registered children's nurse. If one of these members of staff needed to chaperone a paediatrician within a consultation room, there would be no clinical member of staff available in the department. At Pinderfields Hospital, the healthcare assistant explained they would call the staff nurse in Pontefract for advice and support. There did not appear to be a formal process for accessing support from the inpatient services at Dewsbury and Pinderfields Hospitals if the outpatient staff required support.

Medical staffing

- The risk register noted there was a moderate concern regarding middle-grade medical staffing cover which had control measures in place to manage the shortage. However, we talked with three paediatric consultants, a middle-grade doctor and one junior doctor at Pinderfields Hospital who did not feel there were any particular issues regarding medical staffing. Nursing staff did not raise any concerns over medical staffing. At a focus group with junior doctors, these staff were very complimentary about the level of training and support they had received from paediatric medical staff across all locations.

Major incident awareness and training

- There was a trust major incident plan in place that set out actions to be taken for major incidents and other similar events. Staff demonstrated awareness of the plan and one staff member recalled being contacted at home to come into work as part of an exercise. We did not review any training records that showed there had been any specific training in the use of the major incident plan.

Are services for children and young people effective?

Good

Children's services made improvements to care and treatment where these had been needed using programmes of assessment or in response to national guidelines. The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance.

Children and young people had access to a range of pain relief if it was needed, including oral analgesia and patient-controlled analgesics. The service used an evidence-based pain scoring tool to assess the impact of pain. The inpatient ward areas had access to play specialists and a range of distraction tools when required to provide an alternative means to lessen the impact of pain, discomfort or distress.

We reviewed information that demonstrated children's services participated in national audits that monitored patient outcomes, when this was applicable to the service. The children's services clinical areas also submitted ongoing data (where applicable to children) that contributed to the patient safety thermometer monitoring dashboard.

Staff had received an annual appraisal and received good levels of support and personal development. Members of staff gave positive feedback about the individual support they received regarding their personal development.

There was clear evidence of multidisciplinary working across various disciplines and specialities. Medical and nursing staff gave positive examples of multidisciplinary

working. We were told that the paediatricians and nursing teams worked closely and together also worked closely with other allied health professionals such as dieticians, occupational therapists and physiotherapists.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. The head of clinical service explained there was a group which reviewed new guidance and forwarded it to the relevant department for review. The services' clinical governance meeting included a standing agenda item for NICE guidance and included discussion of recently released guidance, for example the most recent guidance for neonates. One of the paediatricians acted as the services lead for the review of guidance and steered its incorporation into protocols where required.
- We were given examples of guidelines that had been reviewed and how these had been audited to check they had been implemented, for example the management of gastroenteritis.
- We were told how other service developments had been made using evidenced-based practice, for example the introduction of carbohydrate master classes for children with diabetes following a diabetes peer review.

Pain relief

- Children and young people had access to a range of pain relief if it was required, including oral analgesia and patient-controlled analgesics.
- The service used an evidence-based pain scoring tool to assess the impact of pain. The pain scoring tool was incorporated into the PAWS assessment tool that was completed by members of staff.
- The inpatient ward had access to play specialists and a range of distraction tools when required to provide an alternative means to lessen the impact of pain, discomfort or distress.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's activities of daily living. Children were able to choose their food from the daily menu with the support of staff and parents. We were told there was not a specific children's menu, but staff were flexible to help meet the nutritional needs of the child.

Patient outcomes

- We reviewed information that demonstrated children's services participated in national audits that monitored patient outcomes where this was applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Project, along with national CQUIN data. The lead paediatrician for the neonatal service explained how the data was monitored and we saw from a report how learning had taken place from the data.
- The children's services clinical areas also submitted ongoing data (where applicable to children) that contributed to the patient safety thermometer monitoring dashboard. Data for June 2014 (and the months before) showed that all clinical areas were scored 100% harm-free.
- Other examples of participation in national audits were discussed with the head of clinical service and the group manager. For example, participation in the national diabetes audit, where the service had recently been peer reviewed as a pilot site for the audit. We were told the diabetes service had received very positive feedback and currently attracted the best practice tariff.
- We were told the children's services do not participate in the NHS friends and family test. An alternative system had been set up to gain the views of children, young people and families about their experiences. Comments books had been set up in various locations within each clinical area and staff encouraged families to complete the books. The ward manager explained how they checked the feedback books regularly and addressed any negative comments. We asked the children's service management team how they would monitor and audit this feedback and we were told this had yet to be decided and agreed via the services clinical governance meeting.

Competent staff

- There were formal processes in place to ensure staff had received training and an annual appraisal.
- Records showed that 94% of staff on ward seven (29 out of 31) had received an annual performance

development review (appraisal). Similar levels of appraisal uptake were found in all clinical areas managed by the service. Members of staff confirmed they had received an appraisal.

- Members of staff gave positive feedback about the individual support they received regarding their personal development.
- We found the children's service had developed good support packages for members of the nursing team. One of the band six sisters on gate 46 at Pinderfields Hospital had developed a 'patient group directions competency assessment package' for the nurses. The package ensured the nurse had read and understood patient group directions before testing their knowledge and understanding.
- The same sister had also developed a 'band 5 development package', which advised new members of staff on how to manage the ward and handle health and safety matters, along with a range of other information. A second booklet included scenarios to help develop skills for responding to different situations as well as a reflective learning log.

Multidisciplinary working

- Medical and nursing staff gave positive examples of multidisciplinary working. We were told that the paediatricians and nursing teams worked closely, and together also worked closely with other allied health professionals such as dieticians, occupational therapists and physiotherapists.
- We were given an example of how a physiotherapist who attends the Dewsbury children's centre (outpatients) had undergone additional training so that they can triage children who attend with displaced hips and refer to the orthopaedic surgeons.
- The children's service had its own children's therapy services team, which included children's physiotherapists, occupational therapists and speech and language therapists. The team was managed by their own head of therapy services, who reported to the group manager for children's services.
- The ward manager was able to give other examples of how the service worked closely with other specialities. For example, the children's team had worked closely with the accident and emergency consultants in setting up the new child assessment unit that had just been built next to the emergency department.

Seven-day services

- The children's inpatient services accessed diagnostic services such as the x-ray department and laboratory during the weekend. Staff did not raise concerns over accessing these services.

Are services for children and young people caring?

Good

Children, young people and parents told us they felt they received compassionate care with good emotional support. We spoke with 7 children, young people and parents/carers who told us they had felt fully involved in the planning and decisions relating to their care.

Parents and children told us they had been well supported during their visits to the children's areas. We observed that staff were responsive and supportive to a child's emotional needs.

Compassionate care

- Throughout our inspection we observed members of medical and nursing staff provide compassionate and sensitive care that met the needs of the child, young person and parents.
- We observed members of staff who had a positive and friendly approach towards the child and parent. Staff explained what they were doing, for example completing their clinical observations.
- The environment was warm and welcoming in all of the children's and SCBU areas. There were facilities available to assist staff in ensuring the child and family's privacy and dignity had been met.
- We spoke with seven parents and children who all provided examples of how they had been provided with supportive care, sometimes beyond what they had expected. For example, parents explained how well different groups of staff worked together to ensure their child's needs had been met.
- We were told the children's services did not participate in the NHS friends and family test. Comments books had been set up recently to gain children, young people and families' views about their experiences.

Services for children and young people

Patient understanding and involvement

- We observed members of staff who talked with children and young people used a level appropriate to their age-related level of understanding. We spoke with one young person who said the staff really knew how to talk with them in a way they understood.
- We spoke with 7 children, young people and parents/ carers who told us they had felt fully involved in the planning and decisions relating to their care.
- Parents and children talked positively about the information they had received. These families also explained how they had been given sufficient information to make an informed choice about their care.
- There was a range of information leaflets available about various treatments and other care available within the hospital. Leaflets available at this trust were written in English. Members of staff explained they could get leaflets interpreted when this was required.
- The ward seven manager explained how they had recruited healthcare assistants who were titled 'family support workers'. These staff were able to support ethnic minority groups because they spoke languages that reflected the needs of the local population.

Emotional support

- Parents and children told us they had been well supported during their visits to the children's areas.
- We observed that staff were responsive and supportive to a child's emotional needs.
- Parents gave examples of how staff supported their children.

Are services for children and young people responsive?

Requires improvement

The children's service planned and delivered services to meet the needs of local people. The trust was in the process of reconfiguring inpatient services at Dewsbury and Pinderfields Hospitals that met national guidelines for the centralisation of children's inpatient services so that improved outcomes could be delivered.

The planned changes to the service had not yet been fully implemented at the time of our visit and the standard operating procedure and operating plan were not yet delivered. We were therefore unable to assess the potential responsiveness of the service delivery after implementation of the change.

We found the children's service at Dewsbury Hospital provided good access and flow to its services and met children's and parents' individual needs. We found there were good adolescent transitional arrangements for adolescents with diabetes. However, the service did not currently have formal arrangements in place to respond to the transitional needs of other adolescents moving to adult services.

Service planning and delivery to meet the needs of local people

- The trust, as part of a wider acute hospitals reconfiguration, was in the process of reconfiguring children's inpatient services at the Dewsbury and Pinderfields Hospital sites. The reconfiguration plans followed national guidance that proposed the reduction in the number of inpatient units and the development of short stay units.
- The vision included the centralisation and specialisation of children's services at Pinderfields Hospital for poorly children so that children with minor illnesses can receive streamlined and timely care locally at Dewsbury and Pinderfields child assessment units.
- We reviewed the plans for the reconfiguration and talked with all grades of staff. We found there were mixed messages in comparing what the documentation stated and what the management team told us. For example, discussion with the head of clinical service, group manager and staff feedback suggested there would be no increase in bed numbers at Pinderfields. We reviewed two different presentations that suggested there was a "more viable option" to staff an additional four beds on gate 46. The ward manager at Pinderfields thought the additional four beds may be "surge" beds (overflow beds), which would be available on the rarely used cluster A. Because of the uncertainty about bed numbers at Pinderfields Hospital when bed numbers and length of stay reduce, it was not clear how responsive the service would be when the change occurs in August 2014.

Access and flow

- We found the children's service at Dewsbury Hospital provided good access and flow to its services. There was

a child assessment unit located within ward seven. The unit accepted referrals from the emergency department and from general practitioners. Children requiring surgery were transferred to gate 46 at Pinderfields Hospital.

- Neonatal babies who required intensive (level one) or high (level two) dependency care were stabilised on the SCBU unit at Dewsbury before transfer to the neonatal unit at Pinderfields Hospital.
- The children's service used an early warning clinical observation system known as PAWS, which helped staff to identify children who were becoming poorly more promptly so that transfer arrangements could be made to a regional centre such as Leeds or Sheffield when required.
- The hospital was part of the EMBRACE network, which was a specialist transport service for critically ill children and neonates in Yorkshire and the Humber region. The management team and all grades of staff told us access to this service for advice and transfer worked very well.

Meeting people's individual needs

- Staff told us there were interpreting services available when they needed them and they did not normally have any issues when accessing these services. Family support workers were employed on ward seven who spoke languages that reflected the local population.
- The children's ward did not have an adolescent bay or ward area. However, we saw that the ward did take account of adolescents needs.
- The hospital had no formal adolescent transitional arrangements in place to facilitate transfer between child and adult services. There was no overarching transition policy or pathway and there was no nominated lead to coordinate the development of such services for adolescents.
- The head of clinical service and group manager explained there were transitional arrangements for adolescents transferring within the diabetes speciality, including jointly run clinics. A physiotherapist in Dewsbury described how they considered and approached transitional arrangements for young people to adult learning disability services.

Learning from complaints and concerns

- The trust submitted complaints data before the inspection but we did not identify any complaints relating to children. The children's management team explained formal complaints within the children's service were few. We were told there were three complaints currently open (one in Dewsbury, two at Pinderfields) with no themes in the complaints received.
- Staff and ward managers we talked with confirmed that complaints received were few and any verbal complaints were usually resolved straight away.
- The children and family services governance committee meeting minutes included a standing agenda item for complaints. The minutes for the May 2014 meeting noted complaints were being responded to in a timely manner.

Are services for children and young people well-led?

Good

We found that children's services were well led at ward and unit level. The service had a clear strategy and vision over the next few years as it reconfigured children's services in the Dewsbury, Wakefield and Pontefract areas. There was an established leadership structure in place within the women's and children's division, though this appeared complex and not fully visible for more junior members of staff. We did not identify a formally nominated non-executive director who championed children's rights at board level.

There were governance processes in place and risks were actively monitored. We found the children's service had an active risk register. During an interview with the head of clinical service and group manager we showed them the four risk registers, When we asked the management team initially they were unclear which the current version was. The management team later forwarded a fifth version of the risk register, which captured current risks for children's services.

Children's, young people's and parent's views were sought using comments books and changes made to practice as a result of feedback were provided using colourful boards. There was a culture of openness and flexibility at ward and unit level that placed the child and family at the centre of decision-making processes.

Services for children and young people

Vision and strategy for this service

- The children's service had a strategy and vision for the future of service provision in Pinderfields, Dewsbury and Pontefract Hospitals. The strategy involved the reconfiguration of children's services using a phased approach over the next few years. The reconfiguration was in progress after consultation with commissioners and other interested parties such as families and members of staff.
- In outline, the trust's plans included a soon to be opened eight-bed children's assessment unit, which has been built next to Dewsbury's emergency department. When this opened, Dewsbury's children's ward seven would close. We were told about and saw data that showed the majority of admissions were for less than 24 hours. Any child who required a longer stay in hospital (over 23 hours with flexibility) would be transferred to Pinderfields' gate 46. We were told by the ward manager at Dewsbury Hospital and the head of clinical service that they had calculated no more than one to two children a day would need to be transferred initially.
- We talked with a number of staff at Pinderfields who expressed concerns about the reconfiguration. Staff understood the reasons why the changes at Dewsbury were occurring and were generally supportive. However, they said they did not know if they were going to have sufficient staff or beds to care for the children from Dewsbury. Staff at Pinderfields did not feel they had been adequately consulted and kept fully informed by the trust.
- We did not identify, either through discussion or in the review of documentation, how the increased bed numbers (if implemented) or increased workload arising from Dewsbury would be suitably staffed. We were told a small number of staff would be transferring from Dewsbury to Pinderfields, but these staff members would be filling vacant posts within the existing establishment at Pinderfields Hospital.

Governance, risk management and quality measurement

- Before the inspection we requested risk registers at trust level and service level. The trust submitted four different risk registers relating to children's acute inpatient services, all of which carried a different title. Risk registers included 'children & family service risk register', 'paediatrics risk register', 'women's & children's 25th June 2014' and 'women's & children's risk register scores 11+, 9 July 2014'.Few of these risk registers captured the same risks recorded for the acute inpatient children's services. This meant the risk registers may not be accurate and different versions would make it difficult to manage individual risks.
- We found the children's service had an active risk register. During an interview with the head of clinical service and group manager we showed them the four risk registers, when we asked the management team initially they were unclear which the current version was. The management team later forwarded a fifth version of the risk register, which captured current risks for children's services. Once clarified we noted there were currently 18 risks listed for children's acute and community services. None of the risks listed were classified as major and all had control measures in place. We reviewed the risks and saw none were currently identified as a major risk, although some were rated at a moderate risk. The risks identified had measures in place to manage the risk appropriately.
- Children's services sat within the integrated care division's children and family services governance committee. This committee included membership from the children's leadership team at ward unit level along with the head and deputy head of clinical service, matron, group manager, children's therapy lead and representatives from the leadership team of the community children's services (Pinderfields only).
- The governance committee met monthly. We reviewed a sample of meeting minutes from 2 April 2014, 13 May 2014 and 17 June 2014 and saw the meetings had a number of standing agenda items covering areas such as infection control, risk, incidents, patient experience and safeguarding. Discussion within the meeting minutes showed that actions were being undertaken to address identified areas, for example medicines management.
- We found the children's service had an active risk register. However five different versions had been shared with us prior to the the inspection. When we asked the management team initially they were unclear which was the current version. Once clarified we noted there were currently 18 risks listed for children's acute and community services. None of the risks listed were classified as major and all had control measures in place.

- The children's service managed ward and unit clinical and environmental risks appropriately. For example, on ward seven local risk assessments had been completed and reviewed regularly.
- The ward and units had held staff meetings. Staff members we talked with confirmed meetings were held and information regularly shared with them.

Leadership of service

- There was a clear leadership structure within ward seven and SCBU, which was well organised. For example, on ward seven the band seven ward manager was supported by band six sisters who were responsible for a team of staff. The ward manager and sisters had processes in place that ensured staff were supported and received training and personal development. Staff spoke well of their manager.
- There was a band seven ward manager for ward seven and the assessment unit. The children's outpatient departments were also managed by the ward manager for ward seven. The band seven ward manager for Pinderfields' neonatal unit also carried day-to-day management responsibility for Dewsbury Hospital's SCBU unit. Band seven managers were supernumerary, although we were told they regularly maintained clinical skills (often to cover where staffing may be tight).
- Each band seven ward manager reported to a senior leadership team. The leadership team was a combined children and family services team for acute and community services. The leadership team for acute services included a matron, therapy lead, group manager, neonatal lead (a paediatrician) and the head of clinical service (a paediatrician). We were told there should be a patient service manager but this post had been vacant for some time and was currently covered by the matron.
- The children's and family services leadership team reported to the women's and children's divisional clinical director, associate divisional director of operations and the associate divisional director of nursing.
- We received mixed messages about awareness of the senior leadership team. All band seven ward managers we talked with told us they did feel well supported by the leadership team.
- However, other grades of staff did not have a clear understanding of who the leadership team were and what they did. Staff told us the leadership team was very not visible. For example, staff said they rarely saw the matron. We talked with the head of clinical service and group manager about their visibility. They felt matron and themselves were in regular contact with staff within the clinical areas.
- Children did not have adequate representation at trust board level. During our interviews of the management team and consultant staff we did not establish that children have a formal board-level non-executive director to promote children's rights and views as required by the National Service Framework for children standard for hospital services. Although there was an executive board lead for safeguarding children, we were not able to identify if an executive lead took formal responsibility for the promotion of children's rights and services.

Culture within the service

- We found there was a culture of openness and flexibility among all the teams and staff we met within the children's clinical areas. Staff spoke positively about the service they provided for children, young people and parents. Placing the child and the family at the centre of their care delivery was seen as a priority and everyone's responsibility.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of community health services.
- The leadership team had clear ambitions for the success of the reconfiguration of the children's services within Pinderfields and Dewsbury Hospitals, although staff did not feel that they had received enough clear information about these changes.

Public and staff engagement

- Comments books had been recently set up to gain children, young people and families' the views of their experiences. The senior management team had yet to decide how they would formally collate and review comments received using the books.
- We were provided examples of where the public's views had been sought. For example, parents had been involved, along with other stakeholders, in a previous meeting about the reconfiguration of children's services in Dewsbury.

- There was currently no forum or other method of engagement that regularly involved children, young people or families in the ongoing development or delivery of children's services across the trust.
- Staff felt engaged at ward level by their respective ward managers and band six sisters through staff meetings and other forms of communication. The head of clinical service and group manager explained that a children's forum would be introduced in September 2014. Other examples of staff engagement included leadership classes for staff and master classes for the management team, though we did not review further evidence to demonstrate that these had occurred.

Innovation, improvement and sustainability

- The head of clinical service told us there were "pockets of innovation" within the children's service, though this was an area the management team wished to develop. The service was introducing a children's forum from September 2014, which aimed to share all innovative practice that currently took place within the service along with learning from other parts of the NHS.
- We found there was good practice that had been developed within the children's service. The children's service had developed a 'patient group directions competency assessment' support package for the nursing team. The package ensured the nurse had read and understood patient group directions before testing their knowledge and understanding. We were told that the assessment package had been well received and was to be used throughout the trust in other adult speciality areas.

End of life care

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

Information about the service

A specialist palliative care team provided care and advice for patients and staff across all of the three hospital sites as well as the community services for Pontefract, Wakefield and Dewsbury. The specialist palliative care team was available from 9am to 5pm, Monday to Friday. Outside of these hours a consultant based at the local hospice provided a telephone on-call service. End of life care was delivered in most wards at Dewsbury District Hospital and generally provided by the patient's usual medical and nursing team. Some patients who developed complicated symptoms would also be referred to the specialist palliative care services team.

We spoke with five patients and/or relative. We also spoke with 13 staff, including: the specialist palliative care team, ward nurses, doctors, consultants, the chaplains, bereavement and mortuary staff.

We observed care and treatment and looked at care records. We received comments from our listening event and we also reviewed the trust's performance data.

Summary of findings

We rated end of life services inadequate for safety, with improvements required for effectiveness, responsiveness and being well-led. We found caring to be good.

End of life care was provided in most areas in the hospital and there was a palliative care team to support staff and give advice. Staff were committed to providing a compassionate service but shortages of staff was impacting on the safety and quality of care given. Staff reported incidents, but these were not consistently reported and timely. Actions from incident investigations did not always lead to changes in practice.

The trust had introduced end of life records, but there was no clear pathway for staff to follow, although one was being developed. There were inconsistencies in record keeping including decisions over whether to resuscitate.

Whilst some staff told us they had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, they displayed a poor knowledge of how this should be applied in practice. This did not ensure patients were appropriately supported to make decisions and that decisions were being made in their best interests.

Patients referred to the specialist palliative care team were seen promptly according to their needs. The specialist palliative care team were committed to

End of life care

ensuring patients receiving end of life care had a positive experience. Bereavement staff supported families effectively, although the chaplaincy services were under pressure to meet demand. Staff communication over the service review at Dewsbury Hospital was poor.

Training on end of life care was not mandatory and staff struggled to attend specialist meetings. There were inconsistent practices across hospital sites and a concern over staff failure to adopt trust policies and procedures. There was no clear faith strategy or vision or end of life champion at Board level.

Are end of life care services safe?

Inadequate

Staff knew how to report incidents; however, we saw a lack of action being taken with insufficient investigation and learning from incidents. Where actions had been identified following incident investigation these were not always embedded in practice.

Following the removal of the Liverpool Care Pathway (LCP), there was no clear pathway for staff to follow when delivering end of life care. The trust had developed its own end of life care records to replace the Liverpool Care Pathway. This had yet to be fully implemented.

In ward areas we observed good infection control practices but observed poor practices by mortuary staff. We found the mortuary required some repairs and redecoration to ensure that effective cleaning could take place.

Incidents

- Staff knew how to report incidents and gave us examples of the types of incidents they had reported. In some cases incidents had been reported but no further actions recorded or it had been considered that there was insufficient information available to investigate. Incident reports from the mortuary showed a range of incidents had taken place. For example, one incident report concerned a patient whose name was unknown. There was no record of what actions had been taken to identify the patient in order to investigate this matter fully.
- Generally, there were two reoccurring themes. The first was that mortuary staff were not always protected from the risk of infection as ward staff had not followed correct infection prevention and control procedures. The second theme was where errors or insufficient identification had been provided for patients who had died. The investigations reported that staff involved in the incidents were made aware of the findings but no trust wide learning was recorded to prevent reoccurrences.
- Some staff told us they did not always receive feedback on incidents they had reported. Managers said that

there was a system for staff to receive electronic feedback via email of the outcome and actions taken regarding incidents they had reported and information was circulated in patient safety bulletins.

Safety thermometer

- We looked at the information relating to the safety thermometer on the wards we visited. This provided up-to-date information about the ward's current status relating to falls, catheter- acquired urinary tract infections, pressure ulcers and new venous thromboembolisms (VTEs). There is no national specific safety thermometer directly related to end of life care.

Cleanliness, infection control and hygiene

- We observed good infection and control practices on ward areas and systems in place to ensure that ward areas and equipment were clean.
- However, we observed poor infection control practices in the mortuary, which did not ensure staff, or undertakers were protected from the risk of the spread of infection.
- There were systems in place to alert mortuary staff of the risk of infection but there was not always sufficient supporting information available on the type of infection. This meant that they may not be taking suitable measures to protect themselves from the risk of infection.
- We observed staff informing an undertaker of a potential risk of infection but they did not have the detail of what type of infection may be present.
- Mortuary staff were observed wearing their own clothing with a long sleeved laboratory coat, this was observed to have some stains on it. This practice did not adhere to bare below elbow procedures which allowed for thorough hand washing. Aprons were available, however staff initially did not know if there were any available and they were not being regularly used.
- The mortuary was in a poor state of decorative repair with damaged walls and broken tiles. This would not allow for effective and thorough cleaning to be undertaken. This was identified on an environmental audit in March 2014, but was not referred to the estates department to request redecoration until July 2014.
- Staff told us the mortuary trolley was not routinely cleaned after each use. The cover had some damage and stitching had come apart. The lack of cleaning after use and damaged cover could increase the risk of infection.

Equipment

- Staff reported that equipment for end of life care was available whenever it was needed such as appropriate syringes to deliver sub-cutaneous medication

Medicines

- The National Care of the Dying Audit May 2014 reported that the trust had symptom control guidelines for end of life care which were reviewed regularly. We saw that these were available on ward areas.
- Anticipatory end of life care medication was appropriately prescribed for patients. This aimed to provide symptom control and pain management.
- Patients told us they received the right medicines at the right time. Relatives we spoke with told us that they considered that patient's symptoms were well controlled.

Records

- The trust audited their 'do not attempt cardio-pulmonary resuscitation (DNACPR) forms. This involved a retrospective case note audit of in-patients on wards at the Mid Yorkshire Hospitals NHS Trust between August and October 2013, but excluded maternity and intermediate care. DNACPR forms were checked for a total of 37 wards across the trust. With 35% of the wards at Dewsbury Hospital included in the audit. Some improvements were found for example the first consultant review within twelve hours had improved from 38% in 2012 to 41%, the patient's resuscitation status was considered at first consultation review had improved from 31% in 2012 to 41%. However, despite improvements in these this meant there was still an inadequate compliance with the procedures. It was also found there had been minimal improvement in the completion of the review section of the reports. The report goes on to detail recommendations across most aspects of the DNACPR processes including standardising documentation, handover documents and communication.
- A safety bulletin had recently been issued to staff to remind them of the importance of involving patients and families in decisions regarding resuscitation.
- We looked at 18 DNACPR forms throughout the ward areas.
- We saw that most DNACPR forms had been completed fully and patients and families had been involved in the decision not to resuscitate.

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- However, on two DNARCPR forms it was not clear if patients or their families had been consulted. In one of the files it stated that the decision was "To be discussed with family," but we could not find a record to confirm this had been done.
- The trust's policy was and best practice is that DNACPR decisions are reviewed not only when the patient's condition changes but also on transfer of medical responsibility. We saw some reviews of DNARCPR decisions had taken place but this was not consistently done.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The guidance document for the Care of the Dying described how patients and relatives were to be involved in their care. The guidance also described actions staff were to take should they consider patients were not able to consent to their care and treatment.
- Training in consent was part of the trust's mandatory training programme. The most recent trust wide statistics for June 2014 showed that 84% of staff had completed this training. This percentage had gradually been improving since July 2013.
- However, staff showed a poor understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Staff recognised that to prevent someone from leaving was a deprivation of liberty but could not describe other potential deprivations.
- Trust wide training on the assessment of mental capacity, best interest decision-making and the Deprivation of Liberty safeguards was not mandatory and staff knowledge of this legislation was limited. The learning disability liaison nurse and the Safeguarding Adults lead nurse were a resource for advice and support to the wards on these issues.
- Training was delivered by the liaison nurse and the Adult Safeguarding lead nurse, but the liaison nurse had not received specific training on how to undertake this role. This nurse's training had come mainly from their nurse training, attendance at conferences and their own interest.
- Issues with mental capacity assessment training was on the risk register and was rated as 12.
- We had concerns about the implementation of the MCA, staff considered it the responsibility of the consultant to undertake the assessment.
- We found the Consent form 4 was available in some case-notes, but the full capacity assessment was not.
- We did not see any documentation available to evidence that steps had been taken to assess and promote decision making by patients. The involvement of families did not necessarily ensure adherence to the principles of the Mental Capacity Act 2005.
- We observed one case where there was a multidisciplinary team meeting considering a decision about withdrawal of treatment and nutrition from an elderly patient with learning disabilities. There was very little discussion of their best interests, the relevant factors were not fully considered and there was no "balance sheet" approach. The decision was instead made largely on the basis of the wishes of the family member. The consultant reported that he had had no specific training on best interest decision-making under the Act. If this was replicated elsewhere in the trust, it would not be possible to be assured that decision-making about the withdrawal of treatment for those who lack capacity was in accordance with the Act.
- We asked a ward manager and a junior doctor if they enquired as to whether a patient had made an 'Advanced Decision to Refuse Treatment'. They reported that they thought either the family would tell them or that it would be in the notes.
- We spoke with staff about their knowledge about Power of Attorney. Staff had poor knowledge of this and told us they did not ask patients or their families if there was a lasting Power of attorney for health and welfare agreements in place. A lasting power of attorney is a legal document that allows people to appoint people (known as 'attorneys') to make decisions on your behalf. The care planning records did not have space to record this and staff told us they did not routinely ask if there were agreements in place. Staff told us patients or their families usually told staff if there were agreements in place.
- A leaflet - 'Consent to examination or treatment' was available, this was updated in 2011. The leaflet did not refer to the Mental Capacity Act 2005or describe what steps would be followed if a patient was considered to not have the ability to give consent.

Safeguarding

- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults.

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- There was a safeguarding lead staff member for the trust. Staff knew who the staff member was and told us they would refer any safeguarding concerns to them.
- All staff we spoke with confirmed they had received training in safeguarding adults.

Mandatory training

- There was a mandatory training policy in place, which described the essential and role specific training that staff were expected to undertake. The trust monitored the figures for each speciality to assess the level of mandatory training completed.
- We looked at staff mandatory training records. Trust wide records confirmed that 94% of staff were up to date with their core mandatory training. Trust wide role specific training data indicated that 78% of staff were up to date with training requirements.
- All staff we spoke with were trained in resuscitation, this was mandatory.
- End of life/palliative care training was not included as part of the trusts mandatory training.

Assessing and responding to patient risk

- We saw a range of risk assessment tools in use in patients' records. These included tissue viability, moving and hand handling, venous thromboembolisms (VTE) and malnutrition risks. These were updated and reviewed regularly to show there was ongoing monitoring of risks.

Nursing staffing

- We saw that wards were busy and staff reported some shortages of staff. The trust were aware of staff shortages and had identified this as a risk.
- Staff told us that sometimes staff were moved around to different wards to cover shortfalls. They told us this affected communication between the staff teams.
- Staff told us there was a rolling recruitment programme in place and that agency staff were regularly used to cover gaps on rotas.

Medical staffing

- The care of each patient was managed by the consultant within the speciality which was most relevant to the patient's condition. Specialist palliative care advice was sought where it was considered to be beneficial to the patient.
- Staff knew that there was specialist palliative care medical staff available to give advice 24 hours each day. This advice was usually given over the telephone.

Major incident awareness and training

- There was a contingency plan in place should the mortuary become full. The trust had agreements with local undertakers, and staff were aware of the circumstances under which they should use this plan.

Are end of life care services effective?

Requires Improvement

During our inspection we reviewed the care records of four patients who had received input from the specialist palliatice care team.

The specialist palliative care team worked to national guidelines which were based on best practice standards.The integrated care pathway for the dying patient had been devloped but had not yet been introduced to most areas. Staff were not always clear on what had replaced the Liverpool Care Pathway.

Care plans were in place however these were core plans, which lacked any detail regarding the patients individual care needs. Therefore, staff could not be be assured that all the patient's needs hadbeen assessed or are being met.

Evidence-based care and treatment

- The specialist palliative care team based the care they provided on the Gold Standards Framework and the NICE Quality Standard 13 – End of Life Care for Adults. This quality standard defines clinical best practice in end of life care for adults.
- The trust had developed new guidance but this was not fully implemented and not all staff were clear on what had replaced the Liverpool Care Pathway.

Pain relief

- Patients told us that staff asked them if they were in pain and offered pain-relieving medicines. Patients said symptoms of pain were well controlled.

Nutrition and hydration

- Patients were supported and encouraged to eat and drink whilst ever they wished to.
- We saw that patients were screened using the Malnutrition Universal Screening Tool (MUST) to identify patients who were nutritionally at risk.
- We saw completed fluid and diet charts to show staff were monitoring patients' intake.

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- Results of the National Care of the Dying Audit (May 2014) showed the trust was below the national average at reviewing nutrition and hydration at the end of life.

Patient outcomes

- Analysis of the National Care of the Dying audit (May 2014) showed that overall, the trust performed well in comparison to other trusts. The trust was below the national average for spiritual care and documenting care after death.
- Patients and relatives were complimentary of the care.
- We saw a range of thank you cards on wards to let staff know of patient and relatives appreciation of the care received.

Competent staff

- The specialist palliative care team had developed an online training package for staff, but reported that uptake on this was poor. The training package had recently been withdrawn from the e-learning portal.
- The specialist palliative care team had recently appointed an end of life facilitator to train ward staff.
- A new policy and end of life care planning booklet was available to replace the Liverpool Care Pathway. There was a plan in place to ensure 50% of staff on each ward were trained before the end of life care plan was implemented. However we saw limited numbers of staff had been trained on how to use this and the implementation was being affected by poor staffing levels, as there was not enough staff to allow for staff training to take place.
- Information at the time of our visit indicated that the end of life plan had been introduced on ward 8.
- The bereavement officer told us they had received training in customer care.
- The end of life care facilitator had an action plan, which described how they were going to work to train staff and promote knowledge and skills regarding the end of life care. Progress of the plan was monitored with completion dates or reasons for delays being recorded.

Care Plans and Pathway

- In response to the national withdrawal of the Liverpool Care Pathway the trust had developed an end of life guidance document, this was currently a draft version. This was yet to be fully implemented.
- The information leaflet 'for relatives and carers for the dying patient' referred to the integrated care pathway and stated that this was 'commonly known as the Liverpool Care Pathway', so this information was out of date and inaccurate. The leaflet was dated March 2012.

Multidisciplinary working

- The specialist palliative care staff worked alongside other medical and nursing to provide advice on care and treatment to patients. The specialist care staff told us that their advice was well received and was followed through to provide pain and symptom control to patients.
- The palliative care advice provided by the specialist team was clearly documented and reviewed regularly.
- Medical and nursing staff told us they had good working relationships with the palliative care team.
- There were leaflets available for patients to describe the role of the specialist palliative care team. This included contact details.

Seven-day services

- The palliative care team were available 9-5pm Monday to Friday. There were plans to extend the hours that specialist palliative care was available, possibly from the Autumn 2014.
- Out of those hours support was provided via a telephone hotline to the local hospice.
- A consultant in palliative care was available to provide advice, usually by telephone 24 hours per day. Staff knew what services were available and how to make contact for advice.

Are end of life care services caring?

Good

We found that patients were treated with dignity and respect. Care was delivered in a timely manner in a sensitive way. Patients and relatives stated they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them; the discussions were documented in patient's records.

The care delivered to patients was good. Patients said they were very satisfied with their care and said staff were respectful and caring but recognised they were frequently understaffed and very busy.

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Compassionate care

- Patients told us they were treated respectfully by staff.
- There were meeting rooms on wards where more sensitive conversations could be undertaken
- Patients and relatives confirmed staff always knocked before entering rooms.
- The trust has a duty under Common Law to arrange for the funeral of patients who die in the hospital where there are no relatives. Bereavement staff told us that there were systems in place to try to trace and contact relatives but if relatives could not be located, a funeral would be organised for the person.
- Patients told us their privacy was respected and staff respected their dignity.
- Staff were aware of what procedures to follow to respect patient's cultural beliefs.
- Patients and relatives told us that staff were "Nice" and "Good". We were told staff responded to patient's needs quickly and they felt "Looked after".

Patient understanding and involvement

- The records we saw documented discussions with patients and families about their care and treatment.
- Patient's relatives we spoke with told us they felt involved in the care.
- We were told that the care provided was "Good".
- One patient confirmed to us they were kept informed about their treatment

Emotional support

- Each of the trusts hospitals had bereavement officers who supported families through the formal processes following a patient's death. There were dedicated rooms available, which offered privacy. There was an appointment system in place to see the bereavement officer; this meant that relatives did not have to wait.
- The bereavement booklet provided some advice and tips for relatives on loss and how to deal with this. There were also contact details of local services that could support people through bereavements.
- The chaplaincy staff told us they offered bereavement support to relatives as well as spiritual support to patients and families. However, the chaplaincy service was struggling to meet demand.

Are end of life care services responsive?

Requires Improvement

Patients referred to the specialist palliative care team were seen promptly according to their needs. The specialist palliative care team were committed to ensuring patients receiving end of life care had a positive experience.

A range of information was made available to patients and their families but this was not available in alternative languages. There was a range of religious and spiritual support available for patients and families. However, the chaplaincy service was struggling to meet demand. Open visiting was available and staff on wards made relatives comfortable to allow them to spend time with patients.

Where possible patients' preferred place to die was respected. Analysis of data for April 2013 – March 2014 showed that 79% of patients died at their preferred place of care. There were systems in place to ensure patients had access to equipment and care at home if they wished to be discharged from hospital.

Service planning and delivery to meet the needs of local people

- The end of life care facilitator had an action plan, which described how they were going to work to train staff and promote knowledge and skills regarding the end of life care. Progress of the plan was monitored with completion dates or reasons for delays were being recorded.
- There were no specific consultation groups in place for patients and the public to contribute to the development of end of life care services in the trust.
- A range of information books were available. We asked the bereavement officer if these were available in alternative languages but was told they weren't. One small part of the bereavement booklet had an alternative language paragraph, so limited information was available to people where English was not their first language.
- There was not a clear procedure in place on how the property of deceased patients should be handled but staff followed the same practice of property being sent to the bereavement office where relatives could collect this.

End of life care

- There was no clear faith strategy or vision for the future, which meant that meeting the needs of local people tended to be more reactive when situations arose rather than specifically developed and incorporated into practice.
- The chaplains felt the service was challenged. The chaplains covered three hospital sites and visited over 1000 patients per month. The chaplaincy staff reported that there had been some cuts to the chaplaincy services. There were now three chaplains who covered a 24-hour, 7 day per week rota: they reported to us that they considered this unsustainable and did not allow cover for holidays or absences. The chaplains did not know if additional staff were going to be recruited.
- Arrangements were in place for multi-faith support. Analysis of the number of visits for different faiths showed that for May 2014 there were 162 Muslim faith visits, 798 Christian faith visits and an additional 856 voluntary visits. In June 2014 there were 80 Muslim faith visits, 1167 Christian faith visits and 707 voluntary visits.

Access and flow

- There was an effective electronic referral system in place for ward staff to make referrals to the specialist palliative care team. There was a recognised triage system in place to assess the urgency of referrals.
- Ward staff told us that the palliative care staff would ask if there were others patients who would benefit from being seen when they visited the wards. Staff told us than on these occasions they would see patients immediately.
- The referral to assessment time information reported that for inpatients, 95% of patients were contacted by the specialist palliative care team within two days. If referrals were urgent, the time scale for contact was within 24 hours.
- Records we saw confirmed that specialist palliative care staff responded quickly to referrals and provided advice on patient care.
- The Electronic Palliative Care Coordination System (EPACCS) was being introduced. This meant that patients who were under the Palliative care team were identified automatically on presentation to other health care providers/departments.
- Where possible, side rooms were prioritised for patients at their end of life. This provided privacy to patients and their families.

Discharge arrangements

- Rapid response for discharge to preferred place of care was coordinated by designated EOLC case managers.
- The team aimed to achieve 100% of patients dying in their preferred location. Currently they were achieving 85%.
- Statistics for April 2013 – March 2014 showed that 79% of patients died at their preferred place of care.
- Ward staff were able to order the equipment to enable their discharge home. Staff told us this was usually available quickly to enable patients to go home but staff did tell of one delay where a suitable bed was not quickly available.

Meeting the needs of all people

- A 'preferred priorities for care' booklet was available where patients could record their care preferences. However, we did not see examples where this was used in practice.
- The mortuary had a viewing suite where families could come to visit their relatives. We visited the area which had comfortable chairs and toilet facilities, but there was no facilities for relatives to get a drink if they needed one.
- Staff told us they tried to accommodate family's wishes wherever possible. Staff told us how one family had wished their relative to stay in the viewing room until their body was released under the early release scheme, this wish was respected.
- The viewing area was religiously neutral so was suitable for use by patients and relatives of all faiths.
- Chargeable car parking was available at all the trust's hospitals. Some relatives told us that staff provided car parking passes to them to ensure that they did not get fines.

Facilities for relatives

- The end of life guidance policy informed staff on how families and friends of patients should be included and informed about the person's care and condition.
- Relatives told us that staff routinely offered drinks and food to them whilst they stayed with seriously ill patients. Only one relative told us that staff had denied them a drink.

End of life care

- If families wished to stay with seriously ill patients, staff tried to find comfortable reclining chairs for them. If there were side rooms available these were sometimes offered to allow families to rest but also are close at hand.
- There were not clear procedures in place regarding the handling of patient's property after they died.
- Staff told us there was a password system in place where relatives who did not live locally could give a password to obtain progress reports on patients. This ensured that staff were speaking to appropriate relatives when discussing confidential information.

Communication with GP's and other departments within the trust

- The palliative care team's annual report showed that the trust provided training sessions to GP's on palliative care.
- On discharge a letter was sent to the GP detailing the events of the admission.
- A telephone hotline service was available during working hours providing telephone palliative care advice for GP's.

Complaints handling (for this service) and feedback mechanisms

- Complaints were handled in line with the trust policy. Staff told us they tried to resolve complaints at the earliest stage possible, if possible at ward level at the time the complaint was made. If patients still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the hospital.
- We saw leaflets in a number of areas around the hospital, which provided information for patients on how to make a complaint and how this would be handled.
- Relatives told us that staff were approachable and they would feel able to raise any concerns they had with them.

Are end of life care services well-led?

Requires Improvement

We found strong positive leadership in the specialist end of life team. The team was passionate about their work in supporting and caring for patients and their families. The development of end of life care was being adversely affected by low staff morale on the wards due to inadequate staffing.

Local leadership on wards was good but ward staff told us they did not have the opportunity to attend ward or end of life lead role meetings. End of life care was not mandatory so there was inconsistent awareness and application of procedures across the hospital. There was confusion over what had replaced the Liverpool Care Pathway, which put patients at risk of inconsistent care. We had serious concerns over the implementation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as staff awareness of these was limited and application inconsistent.

There were governance systems in place to monitor the quality of the service offered by the specialist palliative care service. There was development of tools and innovative practices being introduced but the speed of introduction was affected by poor staffing levels.

There were inconsistent practices across hospital sites, particularly in the mortuary services and not all actions identified in action plans following incident investigations were embedded in practice. There was a lack of a faith strategy or vision and there was no champion for end of life services at Board level. Staff were unsettled about the future of the hospital and how this affected their employment

Leadership of service

- The specialist palliative care team produced an annual report where their operational policy and work plans and priorities for the following year were documented. We were also given a copy of the annual report produced by the team for the year-end 2013.
- The specialist palliative care team was well led. The team met regularly and worked hard to promote good knowledge and practice to ward staff.
- Staff told us that ward staff worked well together and that immediate managers were supportive to them.
- Some staff meetings were held and staff told us they attended if they were on the right shift.
- When looking at the mortuary services across the different sites we found that there were marked

differences in practices and leadership. Actions identified to increase support for services particularly at Dewsbury Hospital following a mortuary review had not fully materialised.
- There was a concern over the staff failure to adopt trust policies and procedures relating to faith and spiritual support matters.

Culture within the service

- The specialist palliative care team were passionate about the work they did and were positive about their role and how the service should develop to improve patient care.
- Staff morale on the wards was poor and impacting on the delivery and development of the end of life care. This was due to low staffing levels frustrating staff efforts to offer care to the quality standard they wished to.
- We were informed that the staff counselling service was being withdrawn so the support for staff would be adversely affected. The chaplaincy staff reported there was an increase in requests for support from staff who were reporting that they were not coping, particularly with staff shortages and moving between wards and sometimes hospital sites.

Vision and strategy for this service

- The palliative care team had a two year work programme which detailed the service developments, improvements and focus up until 2016. There was a clear role with objectives identified which they wanted to achieve. This included providing an accessible, quality service to patients and providing education and advice to primary care, patients and public.
- Some staff were unsettled about the future of Dewsbury Hospital as there were consultations taking place about the future of the hospital. Staff reported that communication from managers about the future of the hospital was poor.

Governance, risk management and quality measurement

- Monthly meetings were held which included inpatient, hospice, and community palliative care managers. The meeting was used to discuss operational issues and the Operational Policy was reviewed and agreed at this meeting. The operational policies were used trust wide so standardising the care patients received.
- There were systems in place to monitor specialist palliative care referrals and care pathways.
- There were action plans in place to address the findings of The National Care of the Dying and Bereaved Relatives surveys. These included target dates and details of progress being made.
- There were arrangements in place to investigate incidents and where issues were highly complex the trust had commissioned external consultants to review and report recommendations for any change to policy or practice. We saw examples where the outcomes to such investigations and reviews were shared with external agencies such as the Trust Development Authority and the commissioning groups.
- The bereavement officers' line management had moved to the Integrated Care Division.
- A mortuary review across all hospital sites had been undertaken in January 2014 and found that there were marked differences in practice and staff arrangements at each mortuary services. For example the mortuary service at Dewsbury District Hospital had lone staff working in isolation but at Pindersfields Hospital staff were based in a central office.
- Themes from the review included incomplete documentation, duplication of forms, missing paperwork and communication issues. On the whole Pindersfields mortuary was found to be working more effectively than the Dewsbury site although there was some inconsistency in following procedures at times.
- An action plan was developed to address issues from the audit, which included regular meetings with bereavement officers , a documentation review to standardise practice across sites and improvements in incident reporting
- However, despite this highlight on mortuary services and practices, and the implementation of an action plan we found that there were still failures to follow procedure, particularly around incomplete and missing documentation. Incidents reported ranged from a case where there was a delay in the repatriation of organs to a body, an incident where a body had to be returned from a funeral director to check identification and a post-mortem had to be stopped as it was unclear whether they were examining the correct body.
- We had serious concerns about the application of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff's awareness of these was generally limited.
- The trust had identified that there was a gap in training for the Mental Capacity Act 2005 and placed this on the

trust risk register (March 2014) due to the small percentage of staff trained. There was no focussed training for doctors who were usually expected to take the lead. There was no clear pathway in place.
- Training with regard to the Deprivation of Liberty Safeguards was also on the risk register.
- There was no audit of patients who fall under the Mental Capacity Act 2005 or of the effectiveness of any assessments taking place.
- The Restraints of Adults Policy (June 2014) stated "Mental Capacity Act training is not mandatory or essential for trust staff". Trust staff could access e-learning on the National Learning Management System. Training in the Deprivation of Liberty Safeguards was not mandatory or essential and was not specifically provided by the trust at the time of the inspection.

Public and staff engagement

- Patient experience and improvement reports were collated by the trust. These consider information from the Friends and Family test, complaints, information form NHS Choices, formal and informal complaints. The latest report from June 2014 highlighted where improvements were needed, and the findings were analysed by speciality. However, as palliative care was delivered throughout the hospital there was no specific data relating to this.
- We looked at the NHS staff survey results for 2013 and saw that the levels of staff receiving job-relevant training, learning or development in the 12 months leading to the survey were in the worst 20% when compared with other trusts. We received feedback from staff about mandatory training. Staff told us that training was available but that staffing levels on the wards meant they could not always attend the courses.
- There were a range of regular meetings held within the specialist palliative care team. This allowed staff to share their views and be involved in decision-making about the service.
- At ward level staff regarded their managers as being supportive. Staff told us that staff meetings were not held regularly as there was, "No time".
- Staff were aware that a staff survey had been conducted but were not aware of the findings of the survey or how these were to be addressed.

Innovation, learning and improvement

- A specialist palliative care facilitator had recently commenced in post to promote learning and training for staff. A range of methods of promoting knowledge and good practice were in place. This included formal teaching and short 'flash' on the job training when staff visited wards.
- A 'Green card' scheme was launched with Macmillan supporting the use of a credit card sized green card with contact details for patients for the specialist palliative care team and other healthcare professionals including district nurses. Patients were encouraged to show this if admitted to hospital or requiring out of hours support to indicate to others that they are known to specialist palliative care services.

Outpatients

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides a wide range of outpatients clinics at Pinderfields, Dewsbury and Pontefract Hospitals. In 2013–2014 over 400,000 patients attended outpatients clinics across all three hospitals, with over 113,000 of these patients attending outpatients clinics at Dewsbury Hospital.

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

The main focus of the inspection was the core outpatients services, which included central bookings, appointments and a call centre based at Pinderfields Hospital. We found there were five dedicated outpatient areas at Pinderfields Hospital and three areas at both Dewsbury and Pontefract Hospitals. A dedicated team of outpatient nurses, receptionists and administration staff provided support to all three hospitals. The focus of our inspection centred mainly within the 60% core service across all three hospital sites.

The service employed approximately 50 nursing staff (registered and unregistered), and 83 reception, administrative and clerical call centre staff to provide and support the core outpatients services.

At the time of inspection there were 17 clinical specialities providing outpatient clinics at Dewsbury Hospital. We inspected clinics for audiology, ear, nose and throat (ENT), cardiology, gynaecology, x-ray and diabetic medicine. We spoke with 13 members of staff and nine patients.

We looked at one set of medical records along with other information provided to patients about their care and treatments. We also looked at the patient environment, cleanliness and availability of equipment.

Outpatients

Summary of findings

We rated outpatients as inadequate for safety and being responsive, caring we rated as good and we rated well led as requiring improvement. We did not rate the effectiveness of the service. There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for assessment and treatment. There had been a validation process in place, which had reduced the numbers waiting, but this had not addressed the risks to patients whose condition may be deteriorating.

There were two separate arrangements in place to manage outpatients clinics, a central system and a system which was directly led by the specialties. The systems operated in different ways. Incidents were reported but learning from these was not always shared so that improvements could be made. Outpatient areas were clean and well maintained with measures in place for the prevention and control of infection. Staff rotated across all three hospital sites depending on need and demand of the service. Outpatient clinics were, in general, comfortable and friendly, with suitable facilities. Essential equipment was not always easily available such as wheelchairs and blood pressure monitors.

Within clinics, staff treated patients with dignity and respect. Patients told us that they were very satisfied with the service they received. However, there were high numbers of complaints going back many months reporting distress and frustration at delays in accessing appointments, multiple cancellations of appointments, changes in location of appointments and the poor communication with the services.

We found audit data in relation to clinic cancellations and delays was available. When we spoke to the manager we were told data was inaccurate and unreliable due to the new PAS system issues. Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%. The trust was unable to give reasons for this. Analysis of data showed from February 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients.

Are outpatient and diagnostic imaging services safe?

Inadequate 

There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for follow-up appointments which could mean there were delays in treatment. Between July 2013 and March 2014 had not put adequate measures in place to manage the backlog of appointments. Since March 2014 specialty level action plans have been in place as a result the back log had been reduced by approximately 10,000 between March and July 2014. However it was unclear how this process addressed the risks to patients whose condition may be deteriorating. Senior managers told us that to date there had been no adverse clinical risks reported from the divisional clinical risk reviews.

Staff were aware of how to follow the trust's policies and procedures for reporting incidents. However, evidence to support how learning from incidents was shared and improvements were implemented was not provided.

It was not clear how staff in the Trust learned lessons from serious incident investigations. Staff were unable to tell us if themes and trends from safety incidents were monitored and acted on.

Implied consent was not being routinely recorded and the processes staff used to assess a person's mental capacity to provide consent was unclear. We were unable to determine from the mandatory training information provided whether outpatients staff were up to date with mandatory training.

Incidents

- Staff were aware of how to follow the trust's policies and procedures for reporting incidents.
- We looked at a sample of the reported incidents within the first quarter of the year and saw these were managed in accordance with the trust's incident management policies.
- We saw the recommended actions and learning from one recent incident had been completed in accordance with the investigation outcomes.

Outpatients

- The senior member of staff told us they provided the staff with verbal feedback from incidents and the health and safety bulletins were available on the intranet, and these were printed and displayed in the staff room for staff to sign once read.
- However, evidence to support informal and formal discussions with staff and on any changes implemented as a result of learning discussions from incidents was not provided.
- We were told the trust had introduced a new patient administration system in September 2013. In October 2013 the trust had identified a high volume backlog of patients across all of the clinical specialties who were overdue for their follow-up outpatient appointments. Staff and senior managers in the trust told us the number overdue was initially estimated to be around 30,000. As of March 2014 this figure was reported as 19,200.
- We found the issue had been escalated onto the corporate risk register and actions to manage the backlog were on-going at the time of inspection. The monitoring of this backlog was being undertaken by the Executive Access, Booking and Choice steering Group, which the Chief Executive Officer was the chair. The issue was also monitored by the Trust Board and the Executive Quality Board..
- There have been four serious incidents recorded on STEIS in 2013/14 in relation to outpatients. Three incidents related to patient care and the fourth incident related to the non-issuing of appointment letters by an external supplier.
- The serious incidents led to a full root cause analysis. Root cause analysis is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again.
- Similar incidents to the issues identified by the trust in October 2013 had also been identified from a root cause analysis investigation in 2012. Therefore it is not clear how the trust learned lessons from the serious incidents in 2012 to prevent similar incidents occurring again.
- The trust had developed an operational plan (updated 30 June 2014) to prevent the backlog of appointments occurring again by implementing a number of actions. At the time of our inspection this work was on-going, but we saw from the plan some actions were taking longer than anticipated and timescales had changed.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used in inpatient areas for measuring, monitoring and analysing patient harms and 'harm-free' care. There is no national specific safety thermometer directly related to outpatients. We found the department did monitor and record any falls on a monthly basis. We found there had been no patient falls recorded in July 2014. Staff were unable to tell us if themes and trends in relation to falls were monitored and acted on.

Cleanliness, infection control and hygiene

- The most recent infection control audit results were publicly displayed and showed the department was achieving compliance scores of above 95% for bare below the elbows, hand hygiene, environment, cleaning and decontamination.
- We saw clinical and non-clinical areas appeared clean and staff adhered to the bare below the elbows policy.
- Staff wore protective aprons and gloves when required and regularly used hand gel between patients.
- Hand washing signage was clearly displayed throughout the department and there was sufficient supplies of hand wash gel available.
- Cleaning audits were publicly displayed and records of cleaning schedules were checked, signed and up to date.
- The outpatients department had link nurses to promote continuous service improvements in compliance with infection prevention and control best practice guidelines.

Environment and equipment

- All of the outpatients areas we visited appeared to have ample seating, with drinks and refreshment facilities nearby.
- We looked at equipment and found it was appropriately checked and cleaned.
- Outpatient clinical and non-clinical areas appeared uncluttered.
- Resuscitation equipment was immediately available for use and daily checks of this equipment were up to date.

Medicines

- Medicines were stored and managed safely, including in locked cupboards and fridges where required. Medicines fridge temperatures were checked daily.

Outpatients

Records

- Senior managers told us that the majority of patient records were held electronically and staff were able to access these records via the trust's secure records data base. We saw computer terminals were available in all of the consulting rooms for doctors to access the patients' records.
- Outpatient clinics also operated a paper patient record for each visit; these records included the patient's personal data, a medical history and correspondence sheet, consultation outcomes form along with patient identification labels.
- We found nursing staff were responsible for checking and recording each patient's height, weight and basic physiological signs, such as blood pressure and pulse rates. We saw these procedures were consistently completed before patient consultations.
- Medical staff completed the consultation records along with the outcomes form, which was passed to the receptionist to arrange follow-up appointments and/or discharge, as determined by the medical staff.
- Staff and managers told us the process was that within five days after consultation, the paper records were scanned electronically into the patient's records.
- Staff also told us the historical paper records and any hard copy records that had not been scanned electronically were issued in advance of the clinics and these records were delivered in a timely manner and stored securely within the department.
- We looked at one electronic patient record and saw it included comprehensive health records such as the patient's medical history, consultation records, care and treatment interventions, medical and nursing notes along with diagnostic test results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Senior staff reported that within the outpatients department implied consent is obtained from the patient before any care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and basic physiological signs. The General Medical Council defined implied consent in their guidance 'Consent: patients and doctors making decisions together' (2008) as "Patients may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken.
- Staff reported that if consent could not be safely obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding team for advice. However, it was unclear the processes staff used to assess a person's mental capacity and ability to make decisions.
- Staff reported that advance notice of people with special needs was provided through the bookings systems.
- The outpatients department had link nurses to promote continuous service improvements for people with learning disabilities. We saw a range of easy-read information leaflets, a learning disability information folder for staff's reference and talk boards to assist people with communication difficulties were available.

Safeguarding

- Staff we spoke with could identify issues of neglect and abuse and they knew the procedures to follow to report and escalate safeguarding concerns.

Mandatory training

- Staff reported that mandatory training was delivered by eLearning and face to face. They reported that reminders were received from their managers when updates were required and that they were up to date with their mandatory training.
- The mandatory training data supplied by the outpatients service showed that over 80% of staff had completed adult and children's safeguarding, fire and information governance training to date.
- However, on this information from the service we found there was no other training data included for other mandatory subjects, such as resuscitation, manual handling and medicines management.
- We also looked at the mandatory training information submitted by the Trust and saw that outpatient's data was included under the division of surgery. We saw the training required did not correspond with the information provided by the outpatient's service. We also found there were differences between the documents on the completion percentages particularly for safeguarding training. For example the data supplied at the time of the inspection by the outpatient's service showed for safeguarding adults training 83% of staff had

completed it. For the same category of training we saw the information provided by the trust showed the completion figure was 100%. From the information submitted we were unable to establish a clear account of the outpatients department's compliance with mandatory training and what training staff were expected to complete.

- According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates. The trust data showed that 71% of outpatient staff had received mandatory resuscitation training.

Assessing and responding to patient risk

- The trust had an 'Observations standard policy for all in-hospital patient care environments' for staff to follow, which sets out the standards for observations for all adult patients who are at risk of, or who are acutely ill, in all patient care environments.
- Patients attending outpatients had baseline physiological signs such as blood pressure and pulse rates taken before their consultation.
- Emergency resuscitation equipment was available for use; emergency medical and nursing staff were available to respond to emergencies.
- From March 2014 the Trust had carried out a clinical validation process led by consultants from within the specialty, who reviewed the clinical notes of the patients, carried out a risk assessment and prioritised patients for follow-up according to their perceived risk. However it was unclear from the Trust's validation process how they had assessed or identified patients whose condition may have deteriorated in the time between their original appointment and the follow-up appointment.

Staffing

- The core outpatients service consisted of a dedicated team of outpatient nurses, receptionists and records staff, which covered clinics at all three hospital sites.
- The current staffing establishment included approximately 50 (registered and unregistered) whole time equivalent nurses, and 83 administrative, clerical and call centre staff to provide and support core outpatients services across all hospital sites.
- Dewsbury's outpatients department had a full complement of qualified and unqualified nursing staff and recruitment for band two administration and clerical staff was in progress.
- Registered and unregistered nurse staffing had been escalated to the departmental risk register. Staffing risk assessments included optimum utilisation of clinic cover across all three hospital sites by rotating staff depending on need and demand of the service.
- There were systems and processes in place to request additional temporary staffing if required to provide cover for unexpected absences.
- Induction and competence training for staff in different roles was carried out to facilitate staff moving between departments.
- There were clear lines of management responsibility and accountability within the outpatients service.
- Nursing skill mix was approximately 20% qualified to 80% unqualified.
- Medical staffing to outpatients clinics along with clinic capacity and demand were agreed and reviewed with each clinical division.

Major incident awareness and training

- There was a trust policy, which staff were aware of and could refer to.
- The senior staff told us that the hospital had been placed on major alert within the last 12 months and the staff had responded in accordance with the trust's major incident policy.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We saw trust policies were based and developed to include nationally recognised guidance such as NICE and Royal College guidelines.

The main outpatients service operated a five-day-a-week service with extra clinics at weekends and evenings to manage the high volume of backlog follow-up appointments. We found that the extra clinics operating at evenings and weekends did not have support from the

phlebotomy service. This meant patients could not have blood samples taken at the time of their outpatient appointment and would have to return to the hospital for this.

Evidence-based care and treatment

- We saw trust policies were based and developed to include nationally recognised guidance, for example NICE and Royal College guidelines.

Patient outcomes

- The majority of patients attending outpatient appointments spoke positively about their experiences.
- The majority of patients commented that they were satisfied with the appointments system and with the care and treatment received at the hospital. One patient said, "I can have an appointment as and when required and I have never been let down."
- We saw patients were kept informed of any delays to their appointment times and sufficient time was allocated for each patient's appointment.
- Staff were seen spending time explaining to patients the procedures they were to have during their visit.

Competent staff

- Departmental appraisal reports showed that 100% of appointments staff, 92% of reception staff, 97% of healthcare assistants and 88% of registered nurses had received annual appraisals.
- Redeployment and sickness, maternity leave and new starters were recorded as reasons for not achieving 100% across all of the staff groups.
- Staff in the core outpatients service told us they received appraisal and supervision. Two specialist members of staff told us they "did not receive clinical supervision" and one commented that they had "never received an appraisal".

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team.
- There was access to multidisciplinary teams and clinical specialists within outpatient clinics. For example, staff gave us examples of how the learning disability specialists had assisted them to care for patients with learning disabilities.
- The trust provided nurse-led clinics and we spoke with two specialists. One told us they attended a multidisciplinary meeting weekly; the other told us they provided a direct service to patients and were supported by other allied health professionals such as dieticians and psychologists.

Seven-day services

- The main outpatients service operated a five-day-a-week service with extra clinics at weekends and evenings to manage the high volume of backlog follow-up appointments.
- Radiology and imaging provided a 24-hour, seven-day service.
- Phlebotomy services were available from 8.30pm to 4.30pm for people to have their blood samples taken.
- We found that the extra clinics operating evenings and weekends did not have support from the phlebotomy service. This meant patients could not have blood samples taken at the time of their outpatient appointment and would have to return to the hospital for this.
- We spoke with the senior member of staff from the phlebotomy service and they said 12 staff provided services to outpatients, inpatients and within the community. The service operated a range of times to cover the workload and main opening hours were from 8.30am to 4.45pm five days a week. Patients requiring regular or special blood tests were given appointment times in order to reduce waiting times. This would build in delay in the results being available to clinicians responsible for the treatment of the patient.

Are outpatient and diagnostic imaging services caring?

Good

Patients and relatives commented positively about the care provided from all of the outpatients staff. Staff working in the department treated patients courteously and with respect.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Compassionate care

- Patients and relatives commented positively about the care provided from all of the outpatients staff.

Outpatients

- We observed all of the staff interacting and speaking with patients in a caring, courteous and friendly and manner.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their appointments and medical conditions.
- Patients also contacted CQC by telephone and wrote to us before, during and after our inspection. There was a mixture of positive and negative feedback; however the common themes were the delay in treatment and difficulties with the appointment system.
- We held a listening event on 14 July 2014 to hear people's views about care and treatment received at the hospitals. We also held community focus groups with the support of Regional Voices who was working with Voluntary Action groups so that we could hear the views of harder to reach members of public. We also received information from members of the public via Healthwatch. There was a mixture of positive and negative feedback relating to Pinderfields Hospital and Dewsbury Hospital; however the common themes for outpatients were concerns about getting outpatient appointments.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes related to outpatients were the long waiting times for outpatient's appointments and car parking cost and availability. The positive themes related to experiences at Pontefract Hospital and the caring staff across all sites.

Patient understanding and involvement

- Patients felt involved in decision-making about their care and treatment.
- Individual outpatient consultation and examination rooms were available to promote and maintain patient confidentiality.
- A range of information leaflets were available, which provided patients with details about their outpatient appointment and clinical supporting literature to assist them in their understanding of their medical condition.

Emotional support

- Staff were always nearby and/or in the consulting rooms to support the patients emotionally in the event of receiving difficult news.

Are outpatient and diagnostic imaging services responsive?

Inadequate

In September 2013, the trust introduced a new patient administration system, which created a number of operational issues in managing outpatient appointments that had the potential to affect the management of patients' clinical risks.

From review of the outpatients overdue follow-ups action plan, we saw for some services such as cardiology and gastroenterology the trust anticipated that all patients would have received a follow-up appointment by February 2015. However, it was not indicated from the information in this action plan, the operational plan or the executive steering group when the trust anticipated all patients who required a follow-up appointment would be seen. It was also unclear from the trust's validation process how they had assessed or identified patients whose condition may have deteriorated while waiting for their follow-up appointment.

The Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%.

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

Service planning and delivery to meet the needs of local people

- In September 2013, the trust introduced a new patient administration system, which created a number of operational issues in managing outpatient appointments that had the potential to affect the management of patients' clinical risks.

Outpatients

- The operational issues identified by the trust following the introduction of the new system involved patients receiving duplicate appointment letters or reminder letters for appointments they had not been sent. At the listening event three people told us they were often confused as to when and where their appointment was and they often received multiple appointments for the same clinic.
- We found patients were not being offered options of an appointment at their nearest hospital and patients we spoke with told us they often had follow-up appointments at a different hospital to their initial appointment. .
- We also found that around the same time there was a five-week period when patient appointment letters were not distributed by the trust's external supplier. This created a high volume of rescheduled appointments, a backlog of follow-up appointments and complaint calls from patients to the appointment call centre.
- The trust had responded by producing plans to validate the backlog of follow-up appointments, which was initially reported to be around 30,000, and to standardise access, bookings and choice operating procedures together with the staffing across all of the outpatients services.
- Clinical divisions produced plans to validate and assess the clinical risks on the backlog of follow-up appointments within their speciality. This process involved consultants within each clinical speciality reviewing patients' medical records. Virtual clinics were set up on the patient administration system to capture the outcomes of their reviews. Consultants were also responsible for advising the trust on the action required to manage any identified risks. Senior managers told us that to date there had been no adverse clinical risks reported from the divisional clinical risk reviews. At the time of inspection the trust reported the outstanding backlog of follow-up appointments at the end of June 2014 was 9501.
- Additional outpatient capacity was arranged when required to ensure patients were seen in an appropriate timescale following the consultant's review. Staff confirmed that extra clinics were arranged at evenings and weekends to help to manage the backlog of appointments.
- From review of the outpatients overdue follow-ups action plan, we saw for some services such as cardiology and gastroenterology the trust anticipated that all patients would have received a follow-up appointment by February 2015. However, it was not indicated from the information in this action plan, the operational plan or the executive steering group when the trust anticipated all patients who required a follow-up appointment would be seen. It was unclear from the Trust's validation process how they had assessed or identified patients whose condition may have deteriorated in the time between their original appointment and the follow-up appointment.
- Each clinical division met weekly to monitor progress and updates from the meetings were presented and reviewed at the Executive Access, Bookings and Choice steering group chaired by the Chief Executive Officer.
- This group was responsible for overseeing and monitoring the governance of the patient access programmes, and the minutes supported the group's governance responsibilities.
- An interim manager had been appointed to manage the outpatients services across the trust. The outpatients operational plan had been updated, with a significant number of phase one actions from April 2014 being transferred to phase two of the programme from July 2014.

Access and flow

- We saw information in the Clinical Executive group (CEG) meeting (10 July 2013), there was a reported backlog of a 1,000 patients requiring follow-up in ophthalmology clinic. It was agreed in the meeting that processes and systems would be put in place to prevent this happening again across the trust. However five months later the clinical lead for medicine identified that 370 patients were possibly at risk of having missed important follow-up appointments. A further 1,500 patients on the diabetic screening database were to be tracked weekly by the service.
- We saw information from the CEG meeting minutes on 18 September 2013 which identified a backlog of follow-up appointments had also been identified in relation to ENT service. We saw in the CEG meeting minutes on the 25 September 2013 the medical director explained to the meeting the issue in relation to ENT was now a wider trust issue. Further information the trust had received identified there were other follow-up

appointments that had been missed particularly in the division of medicine. The Chief Executive requested a centralised system was put in place to ensure measures were put in place to stop a reoccurrence in the future.

- However we saw in further minutes from this group on the 16 April 2014 the Chief Executive had commented that despite significant input to improve outpatient services there had been no noted improvement. This meant since the issue first came to the trust's attention seven month's previously the measures put in place had not addressed the issue and patients were still experiencing delays in receiving their follow-up outpatient appointment and putting them at risk from delays in assessment or treatment.
- The trust provided information as part of the inspection which stated there were still 9,501 overdue follow up backlogs the week ending 14 July 2014.
- The senior manager told us that the trust applied a strict six weeks' notice period of cancellation of clinics. Any cancellation of clinics had to be authorised by the associate directors of operations.
- The managers also told us that within the core outpatients services one-stop clinics were not available except for certain specialities. One-stop clinics are established to help patients get quicker access to a diagnosis and mean they can be seen by multiple clinicians during one appointment. We were told these clinics were available and managed by the relevant clinical speciality, for example oncology and urology.
- We saw patients were kept informed on delays in clinics and waiting times were displayed.
- We found audit data in relation to clinic cancellations and delays was available. When we spoke to the manager we were told data was inaccurate and unreliable due to the new PAS system issues. This meant the service was not able to fully identify any themes or trends and actions to mitigate them where the trust did identify issues actions were put in place.
- The Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%..
- Analysis of data showed from February 2014 the trust was consistently not meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients. The trust had made an agreement with the trust development authority and the local clinical commissioning groups not to meet the target until end September 2014.
- We found the trust was meeting the diagnostic waiting times for patients not waiting over six weeks for a diagnostic test and for all cancers the 62 days wait for first treatment from an urgent GP referral.
- From June 2014 the call centre was achieving 95% of all calls answered within the three-minute response time.

Meeting people's individual needs

- The information signs throughout the hospital were clear. Outpatient's signs included reference to different colours for different outpatient areas. For example the yellow desk was the main outpatient reception area.
- We observed patients reporting to the main reception and staff acknowledged their arrival in a polite and courteous manner. The area was calm well organised.
- Translation services were available for patients by request from their bookings forms. The staff explained the systems and processes in place for arranging translation services.
- The outpatients department had developed link nurses to promote continuous service improvements for people with learning disabilities. We saw a range of easy-read information leaflets, a learning disability information folder for staff's reference and talk boards to assist people with communication difficulties were available.
- Staff told us that for patients attending appointments who were known to have complex needs or required particular privacy, plans to meet their needs were arranged in advance of their appointments.

Learning from complaints and concerns

- The outpatients service had a process in place for managing informal complaints. Both formal and informal complaints and concerns were recorded through the trust's Patient Advice and Liaison Service, as well as informally by the department.
- We saw from the complaints numbers supplied by the trust that complaints peaked in November and December 2013, which coincided with the operational issues referred to earlier in this report. From March 2014 the numbers of complaints and concerns had reduced.
- Following the publication of the 'Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture Report' the trust Board requested six

monthly reviews of complaints. The subsequent review of complaints report covering complaints received from 1 October 2013 to 31 March 2014, showed a high level of dissatisfaction with delays in accessing appointments. The report details extracts from complaints received, one such example was, "I made an appointment as soon as I received the letter. When I checked the appointment the day before going I was told it had been cancelled, so I booked another, only to receive a letter saying that was cancelled too. Could you help me please."

- We saw the lessons learned following the introduction of the new PAS system were reviewed. The senior managers told us that, along with these lessons, learning from concerns and complaints had been included within the revised outpatients operational service plan.
- We spoke with one of the Patient Advice and Liaison Service team and they confirmed that the outpatients appointment processes were a "lot better now".
- However, as part of the inspection process listening events were held and people who used services were invited to attend. We found there were themes from people's experiences that included confusing clinic letters with multiple appointments for the same clinic, people not getting appointments at the hospital of their choice, long clinic waiting times and delay in receiving appointments.
- As part of the inspection process listening events were held and people who used services were invited to attend. We found there were themes from people's experiences that included confusing clinic letters with multiple appointments for the same clinic, people not getting appointments at the hospital of their choice, long clinic waiting times and delay in receiving appointments.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Approximately 60% of outpatient core activity and management is under the responsibility of the Division of Access, Booking and Choice. The remaining 40% of outpatient activity was managed by a number of other clinical services, such as diabetic medicine, ophthalmology and dermatology. There were two separate arrangements in place to manage outpatients clinics; a central system and a system which was directly led by the specialities. The systems operated in different ways.

Similar failures to distribute trust appointment letters to the ones identified by the trust in September 2013 were identified in 2012. Therefore it was not clear how the trust learned lessons from the serious incident in 2012 to prevent this from happening again. It was also not clear what monitoring and governance took place between 2012 and 2013 to ensure the recommendations from the serious incident were implemented and monitored.

Vision and strategy for this service

- The core outpatients services consisted of a central bookings and appointments call centre based at Pinderfields Hospital. There were five dedicated outpatient areas at Pinderfields Hospital and three areas at both Dewsbury and Pontefract Hospitals.
- Managers and staff had contributed to the outpatient operational service plans to improve the quality of the service.

Governance, risk management and quality measurement

- We found the trust had initially identified concerns with follow up appointments in Ophthalmology in July 2013 and ENT in September 2013. On further investigation the trust had found this was an issue across other services. However despite issues being raised in Ophthalmology in July 2013 and then wider Trust concerns about follow up appointments being raised in September 2013 the Trust between July 2013 and March 2014 had not put adequate measures in place to manage the backlog of appointments. Since March 2014 Specialty level action plans have been in place as a result the back log had been reduced by approximately 10,000 between March and July 2014.
- Furthermore the Trust did not have a timescale for when all the outstanding patients would have been seen in the relevant outpatient clinic. The trust provided information on when all patients due would be allocated an appointment date. The information indicated the last specialty to allocate appointments would do so by February 2015.
- The clinical division met weekly to monitor progress and updates on the backlog of follow-up outpatients appointments.

Outpatients

- All of the divisions were represented at the Executive Access, Bookings and Choice steering group chaired by the Chief Executive Officer. This group was responsible for overseeing and monitoring the governance of the patient access programmes.
- Similar failures to distribute trust appointment letters to the ones identified by the trust in September 2013 were identified in 2012. Therefore it is not clear how the trust learned lessons from the serious incident in 2012 to prevent this from happening again. It is also not clear what monitoring and governance took place between 2012 and 2013 to ensure the recommendations from the serious incident were implemented and monitored.
- One of the actions from the 2012 trust investigation report was to develop a service-specific specification/ contractual agreement between the trust and the external supplier. The draft service level agreement submitted as part of the evidence at this inspection does not appear to include any references to previous agreements and is dated 1 June 2014 until 31 May 2015, with options to extend. Therefore it is difficult to determine from the information whether any existing agreement was developed as recommended in 2012 to minimise future risks.
- The Trust has continued to experience issues with the cancellation of outpatient appointments since 2010. This continued to be a major issue of concern for the trust at the time of our inspection. Therefore, despite awareness, actions taken to address this matter were ineffective, which continued to put patients at risk due to delays in treatments.

Leadership of service

- Approximately 60% of outpatient core activity and management is under the responsibility of the Division of Access, Booking and Choice. The remaining 40% of outpatient activity is managed by a number of other clinical services, such as diabetic medicine, ophthalmology and dermatology. There were two separate arrangements in place to manage outpatients clinics, a central system and a system which was directly led by the specialities. The systems operated in different ways.
- Plans were in place to centralise the outpatients services across the trust and staff had been involved and contributed to the change processes recently introduced. This is indicated on the operational plan of 30 June 2014 to be in phase two, but we were unable to identify in the plan when this is due to start or finish.
- The team of nurses, receptionists and records staff all worked together to provide support to all three departments across the trust.
- Staff told us that the leadership of the outpatients services and department had improved since April 2014 with the introduction of a new interim management team.

Culture within the service

- The team worked well to support each other and they were flexible and committed to providing good patient services.
- The service used staff flexibly across the three sites so that clinics were covered. Staff we spoke with were aware of the reasons why this was required.
- Staff told us that the service had improved over the past quarter because of the new interim management structure and there was clear line management, which staff understood.
- Staff were involved in providing their views about improving outpatients services for patients.

Public and staff engagement

- The majority of the staff we spoke with were aware of the trust's values and aims, which we saw were displayed throughout the hospital and departments. Staff were also aware of the Chief Executive Officer's methods of communication and how to get in touch with them if they needed to.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

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

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

Importantly, the action the trust MUST take to improve

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

Outstanding practice and areas for improvement

- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) are embedded in theatre practice.
- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours
- Ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Ensure the recommendations from the mortuary review are implemented and monitored to ensure compliance.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.
- Ensure actions are taken to address the poor decorative state of the mortuary to ensure effective and thorough cleaning can be undertaken at Dewsbury and District Hospital.

Action the hospital SHOULD take to improve

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

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

This section is primarily information for the provider

Compliance actions

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control In the mortuary at Dewsbury and District Hospital the trust had not ensured, so far as reasonably practicable, because we observed poor infection control practices which did not ensure staff, or undertakers were protected from the risk of the spread of infection. Mortuary staff were observed wearing their own clothing with a long sleeved laboratory coat, this was observed to have some stains on it. The mortuary trolley was not routinely cleaned after each use. Due to the poor state of decorative repair with damaged walls and broken tiles the mortuary could not be effectively cleaned. Regulation 12 (2)(a),(b) and (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010: Cleanliness and infection control.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Compliance actions

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

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

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

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

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

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

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust has not safeguarded the health, safety and welfare of service users because appropriate steps have not been taken to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed or retained for the purposes of carrying on the regulated activity. The midwife establishment for the trust is currently 1:31 which is above the recommended 1:28 ratio.

This section is primarily information for the provider

Compliance actions

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe because staff in the divisions of medicine and surgery were not fully aware or up to date with the national guidance and good practice in relation to Deprivation of Liberty Safeguards (DoLS). **Regulation Reg 11(2)(a) and (b) of the Regulated Activities Regulations 2010 Safeguarding service users from abuse.**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Appropriate arrangements were not in place for dealing with the storage, handling, administration and recording of medication. A recent medicines management audit from the trust demonstrated that the safety of medicines had broadly not improved since 2012. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines.