The Mid Yorkshire Hospitals NHS Trust

Pinderfields Hospital

Quality Report

Aberford Road
Wakefield
WF1 4DG
Tel: 0844 8118110 or 01924 541000
Website: www.midyorks.nhs.uk

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care	Inadequate
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. Pinderfields Hospital is situated in Wakefield and serves a population of 325,837 with approximately 639 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 Pinderfields Hospital as requires improvement. We rated it good for being caring and required improvement for being effective, being responsive to patient's needs and being well-led. But we rated it inadequate for providing safe care.

We rated critical care services as good. Accident and emergency, surgery, maternity, end of life care and children and young people's services were rated as requires improvement. We rated medical care and 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 clean.
- The urology department had been recognised nationally for the use of green light laser surgery, which is a minimally invasive procedure for prostate symptoms. The procedure enabled patients to return home within a few hours and return to normal activities within days.

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 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.

Summary of findings

- Ensure recommendations from serious incidents and never events are monitored to ensure changes to practice are implemented and sustained in the long term.
- Ensure there are improvements in referral to treatment times to meet national standards
- Review the skills and experience of staff working with children in the A&E departments, special care baby unit and children's outpatients' clinics to meet national and best practice recommendations.
- Ensure staff are clear about which procedures to follow in relation to assessing capacity and consent for patients who may have variable mental capacity. This would ensure staff act in the best interests of the patient in accordance with the Mental Capacity Act 2005 and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure all staff attend and complete mandatory training and role specific training, particularly for safeguarding and resuscitation. In addition ensure all staff working in urgent care settings undertake where appropriate have level 3 safeguarding training.
- Ensure staff receive training on caring for patients living with dementia in clinical areas where patients living with dementia access services. In addition where appropriate ensure staff are trained on the End of Life care plan booklet and updated on the trust's new policy
- Ensure that issues with replacing pathology equipment are addressed to ensure that equipment is fit for purpose.
- Ensure the pharmacy department is able to deliver an adequate clinical pharmacy service to all wards.
- Ensure staff are trained and competent with medication storage, handling and administration.
- Ensure controlled drugs are administered, stored and disposed of in accordance with trust policy, national guidance and legislation.
- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure equipment in the Accident and emergency department is appropriately cleaned and labelled and then stored in an appropriate environment.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) is embedded in theatre practice.
- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours
- Ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Review the arrangements over the oversight of Gate 20 acute respiratory care unit to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013).
- Ensure the recommendations from the mortuary review are implemented and monitored to ensure compliance.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.

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, although there was confusion over the labelling of clean equipment. 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 children's needs were 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.

Summary of findings

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.
We spoke to 25 patients and their relatives.

Medical care

Inadequate

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.
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. 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 was fully up to date with their mandatory training.
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. During the inspection, we had serious concerns about the shortages of staff and the risks to patient safety on Gate 20 and drew this to the attention of the trust. The trust implemented a number of immediate actions to address the concerns which included reducing the number of beds on the ward from 46 to 40. This enabled the ward to achieve a nurse staffing ratio of one nurse to eight patients with a separate co-ordinator on duty.
Following our inspection, we received information of concern about Gate 12 and 20 in relation to patient safety and nurse staffing numbers. We issued a letter to the trust under section 64 of the Health and Social Care Act and asked them to provide information on Gate 12 and 20. The trust responded and provided information. We found

Summary of findings

serious concerns with the continued management of Gate 20. Following our unannounced inspection beds had been re-opened to manage bed capacity issues within the trust however this meant on the majority of occasions nurse staffing numbers did not meet minimum requirements.
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.
There had been a lot of change to management structures. Patient and staff engagement was improving. However, risks had been identified by the trust, but for some of them insufficient action had been taken to address them or sustain changes where these had been made.

Surgery **Requires improvement**

We rated surgical services as good for caring, but improvements were required for safety, effectiveness and being 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) and at times the arrangements for the access and flow of patients on to the wards and in theatres was ineffective.
Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Staffing establishment 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.

Summary of findings

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). There were dedicated theatres for emergencies but not all specialties had timely access such as for colorectal surgery.

We observed positive, kind care provided to patients and patients spoke positively about the standard of care they had received.

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. 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 critical care service at Pinderfields Hospital as good, but there were improvements required in some safety aspects. Generally nursing

Summary of findings

and medical staffing levels were safe. However, there was insufficient staffing on the acute respiratory care unit to meet with national guidance for the provision of Level 2 care.

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.

Summary of findings

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. Maternity areas were clean and there were effective systems in place to monitor infection control. There was an incident reporting mechanism in place and lessons learnt from investigations were shared. However, staffing levels did not meet best practice 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.

Summary of findings

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, although staff did not always receive feedback on reports. At ward and division level risks were regularly assessed and monitored, with control measures in place. However, we found there was confusion over version control on risk registers.

Staffing levels across all children's services did not always meet national best practice guidance.

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 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. We found there was confusion over

which was the current version of the risk register. 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 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 decsions 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. 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.

Summary of findings

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 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.

Pinderfields 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

Contents

Detailed findings

Background to Pinderfields Hospital

Pinderfields Hospital is part of the Mid-Yorkshire NHS Trust. It is situated in Wakefield and serves a population of 325,837 people in the local area. The hospital has approximately 639 beds.

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

Pinderfields Hospital provides a range of services including: Accident and Emergency, Regional Burns Centre, Regional Spinal Injuries Centre, 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 and plastic surgery, Intensive Care and High Dependency Units, acute Stroke Service, 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 Pinderfields 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

Pinderfields 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. In November 2013, a further inspection found the hospital was also not meeting the standards for records.

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.

Detailed findings

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

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 Pinderfields 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	Inadequate	Inadequate
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 and diagnostic imaging	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 104,699 attendances in the accident and emergency department (A&E) between May 2013 and May 2014 at Pinderfields General Hospital, of which 23,098 were children (under 18 years old). Children had their own waiting and treatment area that was secure. The hospital provided an ambulatory emergency care for patients requiring diagnostic procedures and treatment on the same day using a multidisciplinary approach.

Ambulances had direct access to the resuscitation area. The adult majors area consisted of ten central cubicles, four immediate access team cubicles (which was nurse led) and four lower acuity cubicles. The resuscitation area was able to care for six patients; in times of great demand the number of patients could be doubled as spaces around each area were large. One resuscitation bay was fully equipped for the care of children. Mobile x-rays were available for acutely ill patients, including a full trauma series when required, although some x-rays of the neck needed to be undertaken in the x-ray department adjacent to resuscitation.

A separate minor injuries input area was located next to the majors area. The unit was led by Emergency Nurse Practitioners who were qualified prescribers and able to order x-rays when required.

The children's area was open between 9am and 9.30pm and could care for up to seven patients. The area had its own waiting area and was suitably equipped with toys. Outside of these hours, children were cared for in the adult A&E area.

Mobile patients were initially assessed when booking in at reception and directed to the most appropriate area. The hospital received trauma injuries and a helipad was situated in the grounds to receive patients transported by helicopter from air ambulance providers. Another hospital in West Yorkshire received all major trauma cases and had been the designated major trauma centre for West Yorkshire since April 2013. Patients were also transported to the designated major trauma centre when they had suffered severe heart attacks or leaking aortic aneurisms 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, although there was confusion over the labelling of clean equipment. 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 children's needs were 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.

We spoke to 25 patients and their relatives.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The A&E department was clean and tidy, although equipment was not always identified as being clean. Equipment was checked regularly and staff were observed using alcohol gel or washing their hands between patients. There were systems in place to manage deteriorating patients.

There were processes in place to ensure nursing staff learned from any patient-related incidents in the department. An electronic system was in place for storage and administration of medicines, which had reduced errors and costs. Patients' paper records were kept securely, although there was a risk that confidentiality could be breached with the electronic systems in place.

Consent was gained from patients before procedures were undertaken. Some staff were unsure of the procedures to follow if patients could not give informed consent, although they knew how to raise concerns about adults and children who may be at risk from harm

The A&E department had 12 whole time equivalent consultants in post, which included two long-term locum posts. 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 was only one qualifiedpaediatric emergency consultant available in the department; measures had been put in place to compensate for that.

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 eight 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.

Incidents

- All staff were able to report incidents into the trust's electronic Datix system and could give examples of when they had done so. Staff stated that they always reported incidents.
- Nursing staff reported that individual feedback was given by the lead nurse, although doctors reported this could be more of an ad-hoc arrangement.
- We saw the number of Datix incidents logged in A&E from December 2013 until May 2014. The total amounted to 190, with the most being placed on the system during May. The majority of the incidents related to pressure ulcers and referrals to secondary care.
- 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 across all three A&E departments in the trust.
- 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 was not documented.
- The trust had had three serious untoward incidents across the three A&E departments requiring investigation in the past year. The lead clinician informed us of the lessons, what had been learned, and what had been done to make staff aware.
- Staff were able to inform us how practices had changed as a result of incidents raised. We saw a discharge form for completion when patients were being transferred back to residential or nursing homes. This had been instigated following learning from an incident.

Safety thermometer

- A&E did not have its own patient safety information displayed in the department. However, individual audits were available, for example hand hygiene and cannula insertion. Hand hygiene had scored 100% for May 2014 and cannula insertion 98%.
- We were informed the department were undertaking some work so patient safety information would be displayed in the department.

Cleanliness, infection control and hygiene

- The department was well organised and clutter-free and we saw areas were clean and odour-free. Toilets were clean and well maintained.

- We could not always determine whether trolleys and other equipment were clean and ready to use or not, because 'I am Clean' stickers were seen in use on some items of clean equipment but not all.
- We saw clean commodes were stored in the dirty sluice room which meant they were at risk of becoming contaminated.
- Hand washing facilities and alcohol gel were available in all areas, although one soap dispenser in resuscitation was empty. Staff were seen to use soap and alcohol gel between patients and after undertaking patient care. We saw trust staff were compliant with the bare below the elbow policy. Infection prevention and control was part of mandatory training for all members of staff.
- Cubicles with walls and a door were used for any patients with an infection. After use a deep clean was undertaken. Staff informed us the response for a request for a deep clean was very quick.
- Reconfiguration of the department in 2017 would include additional patient spaces, including a side room with a shower.
- 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.

Environment and equipment

- We saw the environment was spacious and well set out.
- In the paediatric resuscitation area, age-appropriate packs of equipment were available for easy access.
- Invasive and non-invasive ventilator equipment was available in the resuscitation area and there were an appropriate number of emergency 'crash' trolleys for the number of beds. Resuscitation trolleys were checked; we saw a log of checks undertaken dating back to June 2014.
- 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; we saw one piece of equipment labelled appropriately and waiting for repair. We saw two trolleys, which staff informed us were waiting for repair. They were not labelled appropriately. We brought this to the attention of staff and they responded immediately.
- We tested three items of equipment and found them to be in working order.

Medicines

- The department had an electronic dispensing machine for medicines. It required nurses' fingerprints to access it, which was linked to the department's electronic computer system. The system could additionally assign 'error' messages, such as warnings about potential contraindications (where medicines should not be used for a specific condition or in combination with other medicines).
- The electronic system had reduced medication errors by 50% and saved the department £27,000.
- Controlled drugs were also stored in the machine and required fingerprints from two different staff members. Controlled drugs were counted in and out by the machine, but were also checked on a daily basis by the morning nursing staff.
- Access to the locked fridge, which stored certain medicines required to be at a specific temperature, was also controlled through the same system.
- Doctors could provide a 'second' fingerprint, but could not access the drugs directly. Nursing staff were able to 'add' fingerprints to the system, for example when agency staff worked in the department.
- All emergency drugs were stored separately on the resuscitation trolleys as appropriate. Intravenous fluids were stored securely.

Records

- Patient's records were kept securely and were only accessible to healthcare professionals.
- Portable computer screens were available in the department. Although they had screen savers, these took a few seconds to initiate and there was a risk patients' details could be seen by other patients or relatives.
- Documentation of 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 risk assessment had been recorded for older people in A&E, including recording a Waterlow score.
- 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 any procedure was undertaken.
- We found there was no documentation to support or assist clinicians in assessing a patient's mental capacity, although this was available on the trust's intranet. Members of staff were aware of the Mental Capacity Act 2005, although their understanding of how it impacted on their work was generally poor.
- Mental Capacity Act 2005 training was not on the department's mandatory training requirement. However, a senior nurse informed us there was a section on the trust's e-learning website for staff to complete but not all staff had completed this.

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%.
- 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.
- Some staff did not like the e-learning system. One told us, "It's not great."
- Staff were allocated one day on an annual basis to complete the training and was heavily reliant on staff having time to complete it during working hours. The system was not accessible from staff member's homes.
- Staff were individually responsible for completing their own mandatory training, although senior staff regularly checked on whether the elements had been completed and were reminded of the importance of it and the implications of non-compliance.
- The trust's mandatory training included infection control, health and safety and safeguarding.

Initial assessment and treatment

- Patients who walked into A&E would be allocated to walk in, majors or referred immediately into the main area of A&E, according to their presenting complaint. If a patient presented with certain conditions, for example chest pain, they were immediately directed into the main area.
- Children would be directed to a separate entrance, to the children's (paediatric) emergency department, during opening hours.

- If the patient was referred into majors they would be instructed to sit in the waiting room and wait to be called into the initial assessment area, where they would be triaged and seen 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 after 11am 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 inputted into a computer, 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 physiological score and its primary purpose is to prevent delay in intervention or transfer of critically ill patients.
- We saw admission pro-formas for patients with trauma injuries were more comprehensive and alerted staff quickly if further intervention was required.
- The trust had standard operating procedures in place for managing emergency demand in any of the hospitals to ensure risks to patients were minimised.

Nursing staffing

- The department had undertaken a nursing staff review approximately one year ago. 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.
- Approximately two agency nurses were used in the department each day to maintain staffing levels. The department had recently recruited to five band 5 posts and was waiting for their employment to begin later in the year.
- During a 24-hour period the numbers of registered nurses varied from ten during the day to eight at night. Two additional nurses also undertook a twilight shift. Healthcare assistants were also on duty.
- We saw the agreed/funded nursing levels for the day we visited. The actual nursing levels were identical apart from the lack of one healthcare assistant. Their shift had not been replaced. We observed there was a noticeboard to alert patients to the numbers of rostered and actual staff on duty which was visible for patients to see.
- 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. We spoke to a nurse who had joined the A&E team directly after qualifying. They told us they had received three weeks as supernumerary status and worked in all areas of the department and were able to complete a lot of their mandatory training. They informed us they felt well supported by the entire team 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 children's A&E department had eight qualified children's nurses in post, but only seven were on the rota at the time of our visit. 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.
- The department was proactive in managing sickness levels, which were at 4%. This had been as low as 2% two months earlier.

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. The A&E department had 12 whole time equivalent consultants in post, which included two long-term locum posts. There were at least two consultants on duty in the department throughout the day and up until 11pm.

Urgent and emergency services

- 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.
- One of the consultants in post was an emergency doctor in paediatrics. They were based in Pinderfields, but were available across all the A&E sites when required. Any consultants undertaking on-call duties had to be within 30 minutes' travelling time of the hospital.
- Consultants were supported by eight middle-grade doctors. Overnight there was a middle-grade doctor on duty with a consultant on-call from home.
- Locums were used to fill gaps in the middle-grade rota; where possible these were long-term positions or doctors who had previously worked in the department.
- Registrars rotated between Dewsbury and Pinderfields.
- From reviewing the junior doctors' rotas, there appeared to be a sufficient number of staff employed. There are no specific national guidelines or standards for medical cover in A&E departments. As medical cover had been aligned with demand, there was an extra middle-grade doctor employed in the department from 11pm until 6am Friday to Sunday.

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. We saw 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 inside and outside, with a storage facility for waste water. The A&E department had needed to respond to four incidents of this nature each had been evaluated and lessons learned, for example the lack of relatives waiting areas so now relatives would now wait in the staff café.
- Funding had been secured for a day's major accident training for nursing staff, which would include practical sessions.

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. 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.

The A&E department had undertaken the College of Emergency Medicine audits on 11 topics in the past six years, the last one being in 2013. 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.
- Treatment protocols were based on the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine, for example the treatment for asthma, the management of strokes, fractured necks of femur, chronic obstructive pulmonary disease, sepsis, major blood loss protocol and bleeding in early pregnancy.

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.
- Throughout our visit we did not observe any patient in distress with pain.

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 saw staff offering patients food and drink.
- 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 drinks and snacks were also available in the waiting room.

Urgent and emergency services

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 between 7.5% and 8% compared with the national rate of 5%.
- The A&E department had undertaken the College of Emergency Medicine audits on 11 topics in the past six years, the last one being in 2013 on consultant sign-off. Results showed that 86% of all patients had been seen by an emergency department doctor.

Competent staff

- 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 stroke and trans-ischaemic attacks.
- We found 80% of A&E staff had received up to date resuscitation training and received regular updates.
- Consultants took 2.5 specialist programmed activities every week. Staff-grade doctors had specialist programmed activities and study leave built into their rota. Middle-grade doctors had a day a fortnight for training at a regional Yorkshire & Humber teaching day. Junior doctors had designated teaching days, which they were supported to attend.
- New doctors received a three-day induction to the trust. For two of the days, doctors were given information about resuscitation, IT systems, case reviews and x-ray sessions. Medical staff felt much supported in their role by their line managers. We spoke with a middle-grade doctor who told us they felt the department was a good learning environment. They told us, "You get a brilliant education, there are many opportunities."
- Some staff had received annual appraisals. The appraisal was also used to identify training needs and discuss development opportunities. Data we received showed the division of medicine, under which A&E sits, had only achieved 56.6% of appraisals for all staff across all the trust's hospitals.
- Staff could attend peer-led awareness sessions.

Multidisciplinary working

- We witnessed good interactions between doctors and nurses during the inspection.
- Due to the care pathway, elderly patients who had suffered a fractured neck of femur (hip) were rarely seen in A&E; they were admitted straight to the orthogeriatric ward.
- The trust had a 24-hour seven-day-a-week thrombolysis nurse-led service for patients who had suffered a stroke and also provided an early trans-ischaemic attack clinic. There was an allocated neurologist on-call each week, which meant immediate verbal advice, could be gained from them if and when it was required. There was also a clinic the A&E department had access to and could refer patients to.
- There were set protocols (in line with the NICE head injury guidelines) that specified which patients could be referred for a CT head scan without a direct referral. This operated between 9am and 5pm during the week. Outside of these hours, a registrar or equivalent grade was required to discuss with the on-call radiologist. MRI scans were available 24 hours a day, seven days a week.
- Staff in the department informed us multidisciplinary working, for example between specialties, was generally good. Patients requiring referral to psychiatric services were generally seen within two hours by the crisis team. Services were going to improve further in November because the mental health team would be based in the hospital. We were informed referral to mental health services for children and young people was good.
- Discharge letters were created electronically and printed off to either be sent by post to the GP or given to the patient to deliver.
- We saw information for patients requiring specialist services, such as domestic violence, alcohol misuse and advice regarding the early pregnancy assessment unit, which was available at the hospital.

Are urgent and emergency services caring?

Good

We spoke to 25 patients and their relatives. The majority of them were complimentary of the care they had received. Two patients told us either they or their relative hadn't been kept informed of what was happening. We saw examples of caring and compassionate interactions with patients given in a quiet and dignified manner.

Urgent and emergency services

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

We witnessed vulnerable patients being treated kindly. Staff knew how to treat relatives experiencing bereavement with dignity and respect. The chaplaincy service provided 24-hour support if required.

Compassionate care

- In our Intelligent Monitoring Report, March 2014, the trust was not rated 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 encouraged to complete the Friends and Family Test before leaving and we were able to witness this. We saw a number of collection points for completed responses across the department. We saw the results for A+E between April and June 2014 the score was 69-72. These results were above the trust's overall score however the response rate was below the overall trust response at 15.8%.
- We witnessed a patient with a mental health condition being supported emotionally by a member of staff and taken into a side room where they could be spoken with privately.
- We spoke with 25 patients and their relatives. The majority of them were complimentary of the care they had received.
- 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. The majority of patients we spoke with told us they understood what had been said to them and had felt well informed about their care and treatment options.
- Two patients told us either they or their relative hadn't been kept informed of what was happening.
- 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.
- Signposting to areas of the hospital was in English. Braille was also available at the bottom of signs for blind or partially sighted people.

Emotional support

- Patients felt very confident in the staff's ability to care for them appropriately. We spoke with one patient who had returned with chocolates to thank staff for their quick and efficient attention when they had attended the department one week earlier. They told us, "They were wonderful, so careful when they put my face right".
- 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. There was a designated area for relatives to view their loved one, although it appeared very clinical. This was acknowledged by the department.
- 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.
- We were informed relatives could stay as long as they wished in the department after a patient's death. 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.

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

Urgent and emergency services

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 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 problem. Although there were no dementia champions in the department, we saw examples of good care being delivered. Work had been commenced to ensure patients living with dementia received a more responsive service. Complaints and concerns were dealt with appropriately and lessons learned in order to improve patient care.

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.

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 Wakefield and surrounding areas. In April 2014, 2771 patients had arrived by ambulance compared with 2625 in June 2014. In the last financial year, there were 96,594 attendances at A&E.
- Patients who walked into the A&E department were at risk of a lack of privacy and dignity while giving confidential information to staff because of the arrangements at the reception desk. A triage nurse assessed all patients and directed them to the appropriate area of the emergency department.
- Patients arriving by ambulance went straight into the clinical area for assessment. This meant patients were given privacy and dignity during this process. Walking patients were greeted by a receptionist, booked in and triaged as soon as possible. Children were directed to the appropriate waiting area.
- Funding had been approved to increase the trolley spaces in the department. This would provide additional facilities, in particular to meet the needs of bariatric patients and those living with dementia.

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 an electronic system 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.
- 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 particularly poor 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.
- 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.
- 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.
- For each shift there was a designated nurse and consultant (or registrar) overnight, who was responsible for ensuring that this escalation plan was enacted appropriately.
- Ambulatory care patients were cared for by the medical team during weekdays with hours reduced on a Sunday.
- There was a daily consultant-led A&E clinic, which was protocol-driven and was used as a 'safety net'. This would regularly pick up simple issues such as cellulitis, scaphoid fractures, simple burns and simple small finger fractures.
- There was a weekly musculoskeletal clinic run by a consultant with a specialist interest in sports medicine. At this clinic patients who had presented with early knee, shoulder and hip injuries and provide initial comprehensive assessment before referral to the orthopaedic team if required.

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. The trust had recently held a training session to support and train staff in dealing with patients with a learning difficulty. There was no member of staff in the department who specialised in learning disabilities or who took a special interest in supporting those with a learning difficulty. We were informed staff had access to a specialist learning disability nurse if required, who was based in the hospital on weekdays.
- We spoke with members of staff about their ability to help patients with dementia when they attended the department. There were no designated dementia champions for the department and training was delivered once as part of the training for all levels of staff, although not all staff had received it. We witnessed a patient living with dementia in the department. A member of staff placed them in a cubicle that would not increase their anxiety levels; curtains were plain and equipment was minimal. The staff member was quiet and considerate at all times.
- Reconfiguration plans for the department included the provision of a dementia and a bariatric suite suitably equipped.
- The department had access to a bariatric wheelchair and trolley when required.
- 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, although they were concerned the numbers of security staff were going to decline.

Urgent and emergency services

Learning from complaints and concerns

- Information leaflets and posters about how to make a complaint were visible in the department. We were provided with a complaint summary at trust-wide level for December 2013 to May 2014 and saw response rates varied
- There were 52 complaints received by A&E in May 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

We saw a good rapport existed between all levels of staff during our visit and there was strong leadership from the clinical lead for the department. Governance processes were evidenced at both local and trust level.

Plans for the future expansion and reconfiguration of A&E services at Pinderfields and across the trust were widely talked about, with good staff engagement.

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, which staff was aware of.

Vision and strategy for this service

- Staff knew the trust visions and values, but could not name them all: They were 'Caring Respect, High Standards, and Improving.'
- Following consultation with the public and other interested parties, the trust was due to be reconfigured, which would impact on the trust's A&E departments. The long-term vision was that Pinderfields A&E would become the major site. The planned expansion of A&E at Pinderfields was a result of this.
- The project would commence in August 2014 with the movement of paediatric services and was due to be completed in 2017. All staff spoken to were aware of this, and the impact that it would have on the separate A&E departments.
- Monthly clinical reference groups were held to which all consultants were invited, and those who attended fed back to the rest of the department.

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. All staff we spoke with told us they felt confident taking any concerns to their line manager and felt 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 Pinderfields were held every month. A&E monthly governance meetings fed into the medicine division and upwards to the trust's clinical governance meetings. During monthly governance meetings issues discussed included complaints, deaths within 24 hours and admissions to intensive care.
- 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

- The clinical, managerial and nursing lead met once a week to discuss any issues of concern. Doctors and nurses within the A&E department were aware of this.
- Staff told us the entire A&E team worked well together. A good rapport existed between all levels of staff. We were able to see this during our visit.
- We were informed by two members of senior staff that they would always challenge colleagues if and when it was necessary. 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.

Urgent and emergency services

- 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	Inadequate
Overall	Inadequate

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides medical care, including older people's care across three sites. Pinderfields General Hospital in Wakefield has 13 medical wards, including an acute assessment unit (AAU/G12), a coronary care unit (CCU) and an acute care respiratory unit (ACU). The medical division included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, haematology, neurology, spinal injury and stroke care.

We looked at the care records of 21 patients and 14 prescription charts. We spoke with 62 patients and relatives, 14 doctors, 37 nursing staff, five therapists, three pharmacists and three ward managers. We visited seven wards, ambulatory care and the discharge lounge, and carried out observations on the areas we visited. Before the inspection, we reviewed performance information from and about the trust.

At the last CQC inspection in May 2013 the hospital had not been compliant with the Health and Social Care Act (2008) in areas concerning privacy and dignity (Regulation 17), safe staffing levels (Regulation 22), quality and governance (Regulation 10) and record keeping (Regulation 20).

Summary of findings

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.

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. 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 was fully up to date with their mandatory training.

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. During the inspection, we had serious concerns about the shortages of staff and the risks to patient safety on Gate 20 and drew this to the attention of the trust. The trust implemented a number of immediate actions to address the concerns which included reducing the number of beds on the ward from 46 to 40. This enabled the ward to achieve a nurse staffing ratio of one nurse to eight patients with a separate co-ordinator on duty.

Medical care (including older people's care)

Following our inspection, we received information of concern about Gate 12 and 20 in relation to patient safety and nurse staffing numbers. We issued a letter to the trust under section 64 of the Health and Social Care Act and asked them to provide information on Gate 12 and 20. The trust responded and provided information. We found serious concerns with the continued management of Gate 20. Following our unannounced inspection beds had been re-opened to manage bed capacity issues within the trust however this meant on the majority of occasions nurse staffing numbers did not meet minimum requirements.

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.

There had been a lot of change to management structures. Patient and staff engagement was improving. However, risks had been identified by the trust, but for some of them insufficient action had been taken to address them or sustain changes where these had been made.

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. The medical wards were clean and well maintained. In ward areas, 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 records were not fully completed, including the National Early Warning Score and fluid monitoring charts, which could mean a deteriorating patient is not recognised in a timely manner. Staff awareness of safeguarding processes and the Mental Capacity Act 2005 and its application was limited across ward areas.

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. We found this affected all grades of staff. Nursing handovers did not cover all of the patients on the larger wards, for example Gate 20. Staff may have been caring for patients 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 the storage and disposal of patients' own controlled drugs, drugs being signed for before administration and oxygen being administered without prescription.

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.

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.Some areas, such as the AAU, also used a staff newsletter.
- Regular mortality and morbidity meetings were held.

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 each ward. This included information about the last time a patient had a fall on the ward, had developed a grade 3 or 4 pressure ulcer, and had developed venous thromboembolism or urinary infections in patients with catheters.
- The trust was performing worse than the England average for pressure sores and catheter-acquired infections, according to nationally collated data.
- In March 2014 in the patient safety dashboard report, it stated that they had exceeded the monthly and annual trajectory for category 3 and 4 pressure ulcers. They had reported 78 cases against an internally agreed maximum threshold of 18 cases for 2013-14. New pressure ulcer prevention care plans and assessment tools had been introduced by the Trust in February 2014.
- Wards A4, Gate 41 and Gate 42 had the fewest harm-free care days, with Gate 42 being rated red from January to June 2014, except in May when it had an amber rating. Gate 38 and the AAU were rated green 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. We saw sensor mats used in some wards to help detect if patients, who were identified as at risk of falling, were moving without assistance.

Cleanliness, infection control and hygiene

- We found the medical wards were clean and well maintained.
- There were policies and procedures in place to ensure that any patients with an infection were managed appropriately, including barrier nursing procedures where applicable. 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).
- All of the wards displayed information about how long they had been free of Methicillin-resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C.difficile) infections. These timescales varied from a few days to over one year. There was personal protective equipment and alcohol hand gels 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.
- 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.
- From May 2013 to 31 May 2014, the trust performed slightly worse than the England average for MRSA infections, but better for both C. difficile and Methicillin-sensitive Staphylococcus Aureus (MSSA) infections.

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, stand and turn aids 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 and accessible on the wards.
- The resuscitation equipment trolley should have been checked and signed on a daily basis to make sure it was in good working order and that emergency drugs stored

on it were within date. We saw that for most days this had occurred. However, on some wards there were no signatures to indicate the checks had been completed on two to five days over the last three weeks.

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.
- A successful initiative had been introduced of a dedicated team to facilitate patient discharge on seven wards. However, according to trust's figures, just over half of discharge prescriptions were reviewed by a pharmacist, across the trust.
- Trust wide 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 four of them. This confirmed the trust's previous findings from October 2013. One person had not had their prescribed drug for two days, with no explanation given in the records.
- We observed medicine administration rounds by nurses. We observed on four occasions, during the inspection, that 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 the majority of drugs were given to patients in accordance with instructions and charts were signed appropriately. However, a number of errors were noted.
- On Gate 20 we reviewed seven records for patients who required oxygen therapy. Five of the seven were not prescribed oxygen and one patient was prescribed but the chart not signed to say they were receiving the therapy.
- In the discharge lounge we had concerns about the unsafe management of controlled drugs. On one occasion we found only one nurse was signing for the drugs and we found an error in the medicines being given to a patient to take home with them. We drew this to the attention of the staff at the time so that it could be addressed.
- 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 Gate 20 we found controlled drugs that had not been disposed of promptly, resulting in large quantities of these drugs being inappropriately stored.
- 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.
- We found that when medication errors took place staff were directed to further training, generally an e-learning course.

Records

- The standard of record keeping on the wards varied. We reviewed 21 patient records on a number of wards. Most demonstrated risk assessments had been carried out and acted on, and that observations had been recorded and acted upon. However, in four sets of notes on Gate12 (AAU) we found they were not completed fully.
- Additionally, on Gate 41 a patient was wearing a glove (so they could not pull out a catheter tube), but in their patient notes there was no evidence of a risk assessment for the use of the glove. In another patient's notes the patient had bed rails in place, but the patient records stated the patient was confused and to use bed rails with care; it was also documented bed rails were

not to be used. We could find no reason or information as to why bedrails were being used. The documentation was confusing and did not have any information about when the use of bed rails should be reviewed.

- The trust had carried out clinical audits of records and had identified some areas for improvement. The service was working with staff to implement improvements.
- An audit of National Early Warning Scores, dated 23 June 2014, was undertaken on Gate 20. This indicated that only 28.6% of observations had been recorded as prescribed and 22% of fluid balance charts started. This meant patients' care and treatment needs might not have been met and any deterioration in their conditions may not have been noted in a timely manner. The roll out of VitalPac, an electronic observation recording system, was brought forward by the Trust and ward based education was being delivered by the critical care outreach team regarding fluid balance records.
- 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 observed on two wards that doctors had left three computer screens with patient information clearly visible. This meant patient's confidential information may have been seen by other people on the ward.
- 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.

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.
- From training records we noted that training about the Mental Capacity Act 2005 was not part of mandatory training. 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.
- From our discussions, we found that a limited number of staff understood the Mental Capacity Act and were able to identify when it should be used and apply it appropriately. On Gate 20 four nurses had no understanding of Deprivation of Liberty Safeguards or its application. On Gate 20 we observed there had been an inappropriate application of Deprivation of Liberty Safeguards. Patients may not have been appropriately protected or received the treatment and care they required if staff did not fully understand the requirements of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.
- The lack of understanding and awareness of the Mental Capacity Act 2005, and how to use the nursing assessment tool to assess capacity, was recorded on the medicine division's risk register.

Safeguarding

- Staff were aware 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

- Information provided to us by the trust showed that overall core mandatory training 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%, for example mandatory training on Gate 41 was 89%.
- 100% of staff had received moving and handling theory training. However, only 59% of staff on acute medicine, 70% of staff on cardiology 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 was introducing an electronic observation tool (Vital Pac) to allow staff to monitor whether patients were receiving timely repeat observations and their condition was improving, stable or deteriorating. The tool was not yet operational on all the wards.
- The trust had introduced hourly rounding's on wards, where staff routinely checked on each patient at least every hour. This meant that staff could assist patients and also identify any changes in their conditions. We saw the hourly rounding's recorded in the majority of 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 doctors 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. The 1:8 nurse to patient ratio was identified as a trust standard in the November 2013 trust board meeting.
- A new software tool had 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. For example the nurse staffing metrics for May 2014 identified Gate 12 AAU had 30% of staff hours needed unavailable, Gate 38 cardiology and the coronary care unit had 24% unavailable.
- We saw only one ward in the division had its planned staffing level in the month May 2014.
- Gate12 is a 56 bedded acute assessment ward. We saw on 4 days 14, 15, 16 and 27 July 2014 the actual numbers of qualified nursing staff (RNs) was lower than was planned. 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 two or three staff below the planned numbers. Through the night there were two occasions on these days where the number of RNs was one less than the planned number. On the same dates the number of healthcare assistant were one or two below the planned numbers of staff.
- Gate 20 is a 46 bedded respiratory care ward. We saw between 14-18 July 2014 the actual numbers of RNs was lower than was planned for the ward to meet the staffing ratio of 1:8 through the day. The numbers of RNs were one or two less than the planned numbers.
- Gate 41 is a 39 bedded elderly care ward. We saw on the days of 16, 17, 21, 22 July 2014 the actual number of RNs was lower than the planned number to meet the staffing ratio of 1:8 through the day. The number of RNs was one less than the planned. On the dates of 12, 13 16, 17, 21-24, 27 July 2014 the number of RNs on a night shift

were one or two less than the planned number. On five of these nights there were only two RNs this did not meet the standards of one nurse to12 patient's ratio overnight.

- Gate 42 is a 41 bedded elderly care ward. On the 6 and 10 July 2014 there were three RNs through the day. The number of RNs was one to three less than the planned numbers. We found on the 10 July 2014 there had been three falls recorded on the wards Datix incident reporting system. On the unannounced visit we found four RNs and four healthcare assistants (HCA) for 41 patients. Three of the RNs and two of the HCAs were agency staff.
- A2 is a 39 bedded stroke ward. Within ward A2 there was a HASU (hyper acute stroke unit) with 6 beds. We found the nurse staffing levels were one nurse to six patients this did not meet the levels indicated by the national good practice guidelines of one nurse to two patients.
- Managers said that staffing was reviewed at the daily operational bed meetings held four times a day. A situation, background, assessment and recommendation tool was used to raise any concerns. We observed one bed meeting and noted that movement of staff appeared to be based on the levels of staffing rather than matching nursing experience to the needs of the patient, for example an intensive care nurse was moved to a general ward area.
- The divisional team had highlighted that Gate 20 was an outlier in May 2014 for staffing levels and patient safety issues and an improvement plan was in place. However, during the inspection, we had serious concerns about the shortages of staff and the risks to patient safety on Gate 20 and drew this to the attention of the trust. The trust reviewed the staffing levels and care on this ward and closed six beds to bring the registered nurse staffing ratio to 1:8. We observed this had been maintained at our unannounced visit on the 27 July 2014.
- Following our unannounced inspection we received concerning information regarding patient safety and nurse staffing numbers on the GP assessment unit (GPAU) on Gate 12 and Gate 20. As a result, we asked the trust to provide information on patient and staff numbers for the period of 27 July to 21 August 2014. The information provided for the GPAU on Gate 12 showed the minimum nurse to patient ratios had been maintained most of the time.
- However, we found on Gate 20 the beds which had been closed during our inspection had been re-opened and the majority of the shifts did not meet nurse to patient ratios, particularly on night shifts. After reviewing duty rotas provided by the trust we found on the night shifts between 27 July to 21 August 2014 there were 13 shifts which did not meet the trusts minimum staffing levels. On some shifts, for example 3 and 4 August 2014, there was one nurse to 22 patients. We received a further report from the director of nursing on 26 August 2014 which stated the number of nurses on duty on 3 and 4 August 2014 meant there was a nurse to patient ration of one nurse to 15 patients. In the report it stated that during these periods additional support had been provided by the weekend ward sisters team, the clinical site managers and night matrons who visited the ward regularly. However it was not clear if the additional support was available on the ward for the duration of the shift. This also meant the off-duty did not provide an accurate reflection of the number of staff working on the ward.
- 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.
- Wards varied in the number of nursing and healthcare assistant vacancies they had, the highest in May 2014 being AAU with 18% (14.2 whole-time equivalent [WTE]), Gate 20 with 15% (7 WTE) and Gate 41 with 16% (6.4 WTE). In June 2014 the vacancy rate had increased on the AAU to 19.9 WTE but decreased on Gate 20 to 5.3 WTE and on Gate 41 to 13 WTE.
- The clinical commissioning groups were fully engaged with the trust and carried out monthly patient safety walkabouts with members of the local Healthwatch. In October 2013, issues were raised regarding the nurse staffing levels on Gate 43, elderly medicine. An examination of Board papers showed that the risks due to the inadequacy of nursing staff and significant concerns on Gate 43 was reported to the Board with a recommendation that this should be independently reviewed. In November 2013 the trust undertook the Safer Nursing Care Tool Audit which incorporated a review of staffing levels on Gate 43. As a result a further investment in staffing was agreed for the ward.
- 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.

- Board reports indicated that all ward managers had full supervisory status, but during our inspection we observed that most were working clinically for part of each week because of staff shortages.
- Nursing shortages were also experienced across upper gastrointestinal nursing specialist 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.
- We looked at the out of hours medical cover at Pinderfields General Hospital, which was four junior doctors. Two of the junior doctors covered the medical wards which meant they were covering four-five wards each and approximately 160 patients. The other two junior doctors were based on Gate 12 the AAU. There were also two specialist registrars, one covering AAU and accident and emergency and the other for the remaining medical patients within the hospital.
- Junior doctors told us there was a need for more doctors to be available out of hours and at weekends. They told us they were concerned that on occasion the specialist registrar shift for the wards was not covered. 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.
- We were told by the junior doctors often they were very busy and struggled to deal with all of the demands on their time, thus increasing the potential risk of harm to patients.
- 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 across the trust, there was a budget for 11 WTE consultant posts. There were four substantive posts filled at Pinderfields Hospital and three at Dewsbury Hospital. The remaining 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. The trust had recently agreed more trainees, one oncology trainee and one acute medicine trainee who would work on AAU, and four medical training posts from overseas who would rotate through AAU. These posts were being recruited to at the time of inspection.
- We attended three medical staff handover meetings. Not all doctors attended, some doctors arrived late and there were a number of interruptions during the handover. There was an electronic document that doctors used on AAU which had some patient information, including when a patient was reviewed by a consultant and what medical tasks were still outstanding. However, not all patients were discussed. We did not observe any formal tool used to record handover or any risk issues that doctors might have needed to be aware of. We were informed that the VitalPac track and trigger system in use at Dewsbury Hospital, was being rolled out at Pinderfields Hospital; this would support doctors to discuss and prioritise very sick patients and those with high NEWS scores. It was anticipated this would be fully implemented by December 2014.
- There was a stroke consultant ward round for acutely ill patients every day. Other stroke patients were seen twice a week.

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 (REAP), 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. For example, a clinical coordinator role for junior doctors on AAU has been requested and a senior nurse presence seven days a week to support discharge.

Are medical care services effective?

Requires improvement

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 2012/13 indicated that hospital staff did not always do everything to help control pain all of the time.

Evidence-based care and treatment

- 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.

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 ten fluid balance charts; all contained entries but about half were not fully completed.
- The Malnutrition Universal Screening Tool (MUST) 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.
- Pinderfields Hospital was performing worse than the England average for the Myocardial Ischemia (heart attack) National Audit Project indicators. The hospital was performing at 86% compared with 94% nationally for the proportion of patients with a discharge diagnosis of nSTEMI (non-ST segment elevation myocardial infarction – a heart attack) who were seen by a cardiologist or member of their team. The hospital was performing significantly worse (18% 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 (59% compared with 73%) with a discharge diagnosis of nSTEMI who were referred for or had angiography.
- The National Diabetes Inpatient Audit indicated that Pinderfields was worse than the England average in 11 of 22 indicators and better than the average in nine of the indicators.
- Pinderfields was the designated hyper acute service for the trust, with non-acute beds in Dewsbury and Pontefract Hospitals. The stroke services at Pinderfields were assigned a grade of E (worst) by the Sentinel Stroke National Audit Programme 2013. Not all patients eligible had access to thrombolysis and only 43% of patients were admitted directly to the stroke unit within four hours, although a greater proportion of patients were supported by a skilled stroke early support discharge team than other sites/trusts in the region. Actions were taken to improve the service. We were told that more recent results indicated an improvement in the service; however at the time of our inspection we did not see confirmation of results.
- The Annual Stroke Peer Review (18 March 2014) found services 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. Specific data in relation to each hospital was not available. Commissioners' had received negative feedback from patients waiting for gastroenterology services at the trust.
- There was an acute care facilitator on AAU who worked Monday to Friday. Their role was to ensure that key patient assessments such as venous thromboembolism, National Early Warning Score, Waterlow, MUST, MRSA and falls were being completed and to inform doctors and/or nurses of any concerns highlighted.

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. Supervision rates varied from ward to ward within the division. 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 or ward-specific information available.

Medical care (including older people's care)

- 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 majority of the wards we visited, this had not been fully implemented or had only very recently started. We also found there were no routine competency checks in place for nurses who administered medication despite a higher than expected number of medication errors occurring across the trust.
- To ensure continuity of care, regular bank and agency staff who 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.
- 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.
- We were told that psychiatry gave a rapid response on the care of the elderly wards.
- 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. However a respiratory physiotherapist was on-call if required and therapy assistants worked over the weekend. Occupational therapy was being piloted during the day on a weekend on Gate 41 and Gate 42.
- 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. Additionally for discharges only the pharmacy was open until 4pm over the weekend. 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. On A2 there were consultant ward rounds seven days a week to see patients who were newly admitted with a stroke. There was a consultant on-call for thrombolysis if required. Other stroke patients were routinely seen twice a week.

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.

Medical care (including older people's care)

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 friends and family test was very variable across the medical division, with the lowest ratings on Gate 20 and Gate 41 and the highest on Gate 21 and the ACU.

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.
- For the inpatient survey friends and Family test (April to June 2014) both the percentage of respondents and the scores varied considerably across the medical wards. The percentage of respondents was lowest (less than 25% in June) on wards AAU, Gate 20, Gate 41 and Gate 43, and highest on Gate 38, which had a 65% response rate in June 2014. The lowest scores from patients were for Gate 20 and Gate 41, while the highest positive scores were from Gate 21 and the ACU.
- The majority of the 62 patients and relatives we spoke with were happy with the care and compassion they received on the ward. Comments included, "I have been treated like a Queen", "It's very clean and they are very caring" and "It's OK but staff are very busy".
- Patients and relatives believed staff cared for them very well despite the pressure they were under and how busy they were on the wards. However, they felt staff could not always meet their individualised needs. For example, one patient said, "They are short staffed: they try to do the best they can."
- One person told us that they had been asked to sleep over to help look after their relative, "They are short-staffed and X will not keep their oxygen on". Another relative told us they felt they had to sleep over to ensure their relative was safe. Relatives were encouraged to be proactively involved in the care of patients and there were extensive visiting hours. A small number of relatives commented that they had been asked to support patients because the staff were too 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 who required them. There were, however, occasions when call bells went unanswered for significant periods because staff were busy assisting other patients. We observed this in particular on Gate 20.
- Hourly rounding's (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.
- 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 Cancer patient experience survey results for inpatient stays (2013) 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 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 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.

Medical care (including older people's care)

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.
- 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, such as 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

Pinderfields 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 and in place to do so. Medical patients, often 20 to 30 a day, were on surgical wards, which may have meant they were cared for by nursing staff that might not have been trained in their medical speciality. The trust was significantly higher (38%) than the England average (21%) for delayed transfer of care while waiting for further NHS non-acute care.

The majority of patients and relatives felt that they could raise concerns and were confident that they would be listened to. However, two relatives on Gate 20 told us they were not confident that their concerns would be addressed.

Service planning and delivery to meet the needs of local people

- There were 13 different wards at Pinderfields Hospital covering a number of different medical specialties, including cardiology, respiratory medicine, gastroenterology, rheumatology, elderly care and stroke.
- We observed three nursing handovers. Staff discussed each patient's changing needs and any changes in their treatment or health. On the wards with larger number of patients, for example, Gate 20, the staff only received the handover for their patients. Staff were expected to support staff in other parts of the ward and cover breaks with no knowledge of the patients, which may have led to inappropriate and timely care not being given. On another ward with staff shortages, a nurse who transferred from the intensive care unit (ICU) to help cover the shortages was given a handover but at the end of the handover the nurse was recalled and replaced by another nurse from ICU. Handover of patients had to be repeated. We saw in one ward the handover of the patients took two hours.
- Some wards were designated as specialist medical wards, but the vast majority of patients were care of the elderly patients. We found the staffing establishment did not always reflect the acuity and dependency of patients; for example, the staffing levels on the hyper acute stroke unit and on other wards where patients were elderly, often frail, with dementia-related problems who required additional support. This meant there was the potential that staffing levels were not sufficient to meet people's needs. We observed this during the inspection on Gate 20 and raised concerns with the management. Following the inspection the management reduced the number of beds by six. However, at the follow-on unannounced inspection staff told us that the reduction in beds had made little difference to the workload because of the acuity and dependency of the current patients.
- 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 AAU, 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 in the case of patients who had had strokes.
- Information provided by the trust indicated that for every month during 2013/14, the average length of stay in AAU was longer than 24 hours, ranging between 24 and 30 hours. During our inspection there were a number of patients (five on 15 July 2014) who had been on the ward for days; we were told this was because there was a lack of appropriate beds elsewhere. Every month in 2013/14 at least one patient was on the ward for seven days or more.
- A number of nurses we spoke with felt there were some problems with inappropriate patient transfers between medical and surgical wards. For example on 27 July during the unannounced inspection we were told that five medical patients were about to be moved to surgical beds so AAU could take five patients from A&E. These transfers were to take place after 10pm.
- Medical staff told us there were often 20 to 30 medical patients (outliers) on the surgical wards. Data from 1 June to 11 July 2014 indicated that the number of medical outliers on any one day ranged from five to 35.
- We attended a bed management meeting 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 and the executive director who was on-call. The meeting was to try and ensure patient flow throughout the hospital and REAP 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 with 6% delayed compared with the England average of 19%.
- There was an in-reach team for older people and discharge coordinators based on Gate 41, Gate 42 and G43 who facilitated discharges Monday to Friday and where possible planned discharges for the weekend. Nursing staff spoke highly of the coordinators and how well they supported the discharge process.

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 with dementia on Gate 20 where the scheme was not operational.
- The trust was working towards achieving a nationally agreed dementia 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. We saw in the trust Quality account 2013/14 they had improved against the CQUIN target for dementia at 40% for all 3 indicators, although this was still below the national target of 90%.

- A dementia screening team had recently been appointed to work across the hospital to ensure all acute admission patients over 75 years were screened for dementia.
- There was a plan to improve ward environments for people with dementia, for example, large clocks with the date and time in each room. We saw the newly refurbished and re-opened Gate 43 which demonstrated this.
- 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.
- On some wards there was specific information about the number of staff who had undergone dementia training. We noted almost all staff on Gate 41, Gate 42 and Gate 43 had received the training.
- 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.
- 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.
- 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 disruptive as possible. We noted that a patient who had learning disabilities had a carer present 24 hours a day. The patient had a 'VIP passport', which they had brought with them that included specific information about them to help NHS staff understand their care needs. There was no specific pathway recorded in the patient's notes.
- 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.
- There was a self-medication policy in place, but staff told us this was not generally encouraged on the wards. Patients might have lost some of their independence if they were discouraged from taking their own medication such as inhalers and insulin.

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. One example was about poor nursing care and the lack of privacy and dignity on Gate 43. The trust acknowledged that there had been a number of complaints relating to care on Gate 43, which led to a decision to temporarily close the ward.
- The Ombudsmen upheld four complaints, two of which were about Pinderfields Hospital relating to lost possessions on an elderly care ward and the communication of a DNACPR decision with the family.
- There were 103 medium graded complaints across the medicine division and 106 low graded complaints, one example related to the delay in communicating cardiology test results, which in turn delayed a patient's treatment. The trust acknowledged in the review that there been a backlog of test results and that actions had been taken to address this problem.
- 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).

Medical care (including older people's care)

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. One staff member commented, "Senior managers shared learning with us, such as improving intentional rounding on Ward 42".
- 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. Two relatives on Gate 20 told us they were not confident that their concerns would be addressed.
- The number of days since the last compliant was displayed at the entrance to each ward.

Are medical care services well-led?

Inadequate

Leadership throughout the division had lacked stability and direction because of many staff changes. The senior division 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 current senior leadership had a good understanding about their roles within the division and were aware of the risks 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.

The trust 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 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, insufficient action had been taken to address them.

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 introduction of the acute ambulatory care model and changes to the care of the elderly wards.

Governance, risk management and quality measurement

- We saw in minutes of the Quality Committee 12 December 2013 there had been an allegation of neglect on Gate 20 by the patient's care home. This allegation had been referred to the local authority safeguarding adult's board and the allegation had been substantiated. Information in the minutes highlight that Gate 20 is a pressurised area, there had been poor documentation on the care management of the patient. As a result the senior nurses responsible for the ward had developed an action plan to address the concerns.

Medical care (including older people's care)

- As part of our inspection CQC raised concerns with the Chief Executive about patient safety and nurse staffing on Gate 20. The trust implemented a number of immediate actions to address the concerns which included reducing the number of beds on the ward from 46 to 40. This enabled the ward to achieve a nurse staffing ratio of one nurse to eight patients with a separate co-ordinator on duty.
- The trust provided information about Gate 20 after our announced visit to detail the actions they had taken. In this review it stated a review of Gate 20 had taken place in May 2014. This was undertaken by the senior nursing team following increasing concerns about the evidence of patient harm on the ward. This included three severe incidents reported between April and June 2014 associated with the care delivered to patients on the ward. The key themes from these were continuity of care plans, the lack of NEWs (National Early Warning Score) being recorded, inadequate escalation of NEWS and management of the deteriorating patient, delays in senior medical reviews and staffing ratios. An action plan had been developed and on the week of our inspection one of the matrons had been moved to the ward to implement these actions.
- However, concerns were first raised with the trust in December 2013 about the risk of patient harm on Gate 20. Further information came to the trust attention in May 2014 in their own review in the continuing risk of patient harm on the ward. Despite this at the time of our inspection significant concerns remained. This meant the trust had not taken appropriate and sufficient actions to mitigate the risks to patient harm since they first became aware of concerns seven months previously.
- The main objective of the Commission is to protect and promote the health, safety and welfare of people who use health services. Following our inspection, we received information of concern about Gate 12 and 20 in relation to patient safety and nurse staffing numbers. Section 64 of the Health and Social Care Act (2008) gives CQC powers to require any information that it considers "necessary or expedient to have for the purpose of any of its regulatory functions". We issued a letter to the trust under section 64 of the Health and Social Care Act and asked them to provide information on Gate 12 and 20.
- The trust responded and provided information particularly on patient numbers on the wards, number of beds opened, staffing numbers, risk assessments which had been undertaken and any actions which had been taken to reduce risks identified. We found serious concerns with the continued management of Gate 20. Following our unannounced inspection beds had been re-opened to manage bed capacity issues within the trust however this meant on the majority of occasions nurse staffing numbers did not meet minimum requirements. Between 27 July to 21 August 2014 the trust informed us there had been ten low or no harm falls on the ward and five incidents of category 2 pressure ulcers.
- The director of nursing confirmed to us on the 22 August 2014 beds had been re-closed to maintain nurse patient staffing ratios. The trust has been requested to provide CQC with daily updates on nurse-to patient ratio's and any patient harm which has occurred.
- Wards used and displayed quality information and the safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action plans were put in place to improve performance. The timeliness of action following concerns being raised was not as responsive as it might have been. For example, an action plan was produced for Gate 20 dated 23 June 2014 that included "Management of and maintaining safe staffing levels 1:8 as a minimum". This had not been implemented at the time of our inspection.
- There were regular, usually monthly, governance meetings for the division of medicine and the outcome of these was fed back to staff via email, and some wards used newsletters, such as "AAU News", which had started in April 2014.
- There were risk registers at a number of levels within the trust from Board to division. On review of these they 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 a lack of clarity 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 division 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 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.
- There was a management structure in place in the wards we visited. Wards had a band 7 ward manager. Ward leaders had limited supervisory time because of staff shortages.
- Matrons were in post within the division to oversee operational issues and assist with arranging additional staff. Two of the matrons had been recently appointed to the trust. Some matrons covered more than one site and staff said they felt some matrons were therefore not as visible or 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 showed they were lower than the national average; 34% of staff said they were able to provide the care that patients needed and only 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 had been proactively encouraging and facilitating staff engagement. This had 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 was introducing 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 the audit results
- 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.
- Gate 43 had been refurbished to create a more dementia-friendly environment.
- Pilot schemes ran 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

Pinderfields Hospital provides a range of surgical services, including general surgery, urological and gynaecological surgery, ENT, ophthalmology, day surgery, burns and plastic surgery and interventional radiology. There were approximately 168 surgical inpatient beds. There was also a surgical admissions unit, a surgical short stay unit and a pre-assessment ward. There were 15 operating theatres.

We visited all the surgical wards, the regional burns unit, interventional radiology, the admissions unit, the surgical short stay unit and pre-assessment ward. We also visited the operating theatres.

We talked with 29 patients and 60 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 10 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 being 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) and at times the arrangements for the access and flow of patients on to the wards and in theatres was ineffective.

Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Staffing establishment 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

Surgery

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).There were dedicated theatres for emergencies but not all specialties had timely access such as for colorectal surgery.

We observed positive, kind care provided to patients and patients spoke positively about the standard of care they had received.

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. 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 the 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. A few staff reported

they did not get feedback regarding incidents they had reported. However, key learning points were included in patient safety bulletins which were circulated to all staff via email on a weekly basis.

- 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. For example, on ward G31, after changes in the ward layout, it had been 158 days since the last patient fall.
- Data showed 98% of inpatients had received a VTE risk assessment on admission to hospital. This was against a target of 95%.

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.
- 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 the 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 ongoing 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 that the anaesthetic machines in theatre had been checked on the day of our inspection. However, a review of the checklist folder demonstrated a number of gaps where daily checks had not been carried out and recorded in line with national guidance.
- Records showed equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.

Medicines

- Medicines were stored correctly and securely on the wards.
- 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.
- Fridge temperatures were checked daily on the wards, but we found checks were not being carried out consistently in theatres. Records showed that fridge temperatures had been monitored on the day of our inspection, but there were gaps in records for the last six months with checks being carried out approximately once a week. This meant staff would not know if the medication had been stored within the correct temperature range in between the checks and if the medication remained safe to use.
- We observed nursing staff administering medications on the ward wore red aprons to minimise interruptions.
- Patients waiting to be discharged told us they hadn't waited long for their take home drugs and that they had received sufficient information from staff about their medicines.

Records

- Care pathways were in use, for example, patients who had suffered with a fractured neck of femur.
- The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Records we looked at were completed accurately.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Minutes from the clinical governance meeting in March 2014 reported the 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, the majority of consent forms were signed on the day of surgery. This meant patients had not received a copy of the page documenting the decision-making process before they arrived for the procedure.
- All patients we spoke with 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.

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 in 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 Pinderfields site 96% had been fully completed. Compliance across the whole trust was 61%.
- We observed three theatre teams undertaking the 'five steps to safer surgery' procedures (World Health Organization (WHO) checklist). Although some steps were being completed correctly, formal briefings before and after surgery were not taking place consistently. Staff confirmed that the WHO checklist was not yet fully embedded across all theatres.
- 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.
- Staff on the surgical assessment unit told us sometimes it seemed liked an impossible task to try and meet patient needs in a timely way, although improvements had been made to increase staffing in the last six months.
- The division had identified staffing levels in theatres as a key risk. The theatre vacancy rate according to the June 2014 workforce information was 15.6%. Staff told us the staff recruitment process was cumbersome and had led to staff taking up offers elsewhere.
- The use of agency staff in theatres was high. Data from theatre allocation lists showed 75% (3 out of 4) theatre lists used agency staff. The interim theatre manager told us agency staff were being booked on a three-month basis to provide continuity of care.
- Staffing levels in the Post Anaesthesia Care Unit (PACU) were below the British Anaesthetic and Recovery Nurse staffing guidelines. Part of the establishment arrangements within PACU was that the qualified member of staff was supported by the theatre team and a second theatre team was available on call if further support was required. However, staff told us by seeking help from theatre staff or retaining the anaesthetist to recover patients, theatre lists could be delayed.
- Staff told us with one recovery nurse on duty in PACU at nights, there were often occasions when, if the dedicated theatre team was working in theatre, there was no additional support in recovery. Although there were mechanisms in place such as an emergency call bell for assistance, this was felt to be insufficient support. The lack of assistance could prove to be an issue if, for example, the nurse needed to get water for patient medicines because these facilities were situated outside of the unit. This meant patients would either have to wait for medications or the nurse would have to leave the unit unattended if no-one was available to assist.
- Nursing handovers occurred twice a day, using patient information from the ward electronic system. We observed a handover on the surgical assessment unit and found this was comprehensive and identified any risks regarding patient care. Daily safety briefings took place.

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 understaffing at consultant level for oral and maxillofacial surgery. We discussed this with the divisional management team who were aware of the risks of 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 a local agreement was in place with a neighbouring trust for the referral of patients as an interim measure 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 to support 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).

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.

Although some improvements had been made to facilities in the surgical short stay unit, the layout and facilities in the waiting area did not promote privacy and dignity for patients.

There was effective communication and collaboration between multidisciplinary teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

Evidence-based care and treatment

- Patients were treated based on guidance from the National Institute of Health and Care Excellence, the Association of Anaesthetists of Great Britain & Ireland and the Royal College of Surgeons. We saw discussions in the minutes of the Clinical Governance meetings about NICE guidance. 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). Some staff raised concerns that there was not a dedicated general surgery list. We were informed that funding was being agreed to provide a general surgery-only CEPOD list.

- 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 most areas.

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.
- 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 femur were seen within 48 hours compared with the national target of 87%.
- 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 was nearing the national norm.
- Day case surgery was performed below national expectation for several specialties such as 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.

Surgery

- The average length of stay between December 2012 and November 2013 showed most surgical specialties were better than the national average with the exception of trauma and orthopaedics.
- 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.
- Some staff told us that although training opportunities were available, it was sometimes difficult to attend because of staffing pressures on the wards.
- Most junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns. The GMC National Training Survey 2013 identified no risks in these areas.
- Revalidation and clinician outcomes were assessed and monitored by the Medical Deanery.

Facilities

- We visited the short stay surgical unit (SSSU). Some improvements had been made to the environment following concerns raised at a previous CQC inspection. The unit had improved accommodation for overnight stays, which included showers, night lights and provision of hot meals for patients.
- However, the layout and facilities in the waiting area did not promote privacy and dignity for patients. There was no dedicated facility for male patients who we observed were sat in hospital gowns behind a curtained partition in the main waiting area. No concerns were raised about the facilities by patients that we spoke with.

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, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- 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.

Surgery

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 SSSU said, "Very positive experience, the nurses have been caring and responsive" and another patient on the regional burns unit said, "The care is outstanding, staff take time to speak to me."
- 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 the June 2014 data for surgery, which showed 67% of patients were 'extremely likely' or 'likely' to recommend the service to their family and friends.
- 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 other areas of the trust. The positive themes related to the caring staff across all sites.

Patient understanding and involvement

- Most patients felt they understood their care options and were given enough information about their condition. However, six patients on the surgical assessment unit ambulatory care facility said that they didn't know what was going on and felt unable to ask questions because the staff were "exceptionally busy".
- 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.
- 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.
- 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.
- There was information within the care plans to identify whether patients had emotional or mental health problems.
- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.
- Patients were able to access counselling services, psychologists and the mental health team when required. A ward-based clinical psychologist was available for patients on the regional burns unit.

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.

Surgery

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.

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. 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 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.
- Staff informed us that sometimes patients would have to wait in PACU before a bed was available on the wards. During our inspection one patient had been waiting in PACU from 11.30 – 16.30 for a bed. The reason given for the waiting time was because there was no suitable mattress available.
- There had been a number of complaints received about access within the surgical services relating to waiting times. According to the Division of Surgery Patient Experience Improvement Plan (25 April 2014), "There were a number of complaints within the division relating to waiting times in each department, waiting for theatres, waiting for procedures and waiting for a doctor review, decision making or management plan".
- The division had outlier guidelines, which included criteria for the suitability of patients to be transferred. Staff reported that it was common for medical patients to be cared for on surgical wards. Records showed that over a 41-day period (1 June to 11 July 2014) there were 825 medical patients placed on surgical wards. Staff told us patients were reviewed by the medical teams.
- There was no dedicated gynaecology ward and acute patients were admitted to wards where they were managed by non-gynaecology staff. An action plan was in place but this was not yet fully implemented.
- We visited surgical assessment unit in the evening and found a number of patients had been waiting between 8 and 10 hours for medical review in the ambulatory care facility.
- Patients attending short stay surgical unit (SSSU) were admitted at 7 am for all day surgical lists. Staff told us if

surgery was planned for the afternoon, this meant patients were without food or fluids for several hours. A review was being undertaken of patient waiting times and data showed changes had been made; for example, patients for ENT lists were being admitted later in the day. Work was still ongoing in terms of the scheduling of patients and the admission of patients pre-operatively to the unit.

- Risk assessments were carried out to identify patients who were suitable for admission to the SSSU. Regular meetings were held between senior staff to assess the number of patients who were safe to stay in the unit overnight pending the number of admissions the following day. Plans were made for discharges within 23 hours of arrival at the unit. Records for a three-week period showed patients were transferred to another ward or discharged within this timeframe.

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.
- 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.
- In May 2014 alone, the division of surgery received 41 formal complaints; 98% of these were responded to within agreed timescales. The main themes related to clinical treatment, appointment dates and waiting times.
- 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.

Surgery

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, which had resulted in low staff morale.

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.
- 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. One staff member on SSSU said, "team working is really good; there have been vast improvements since the service started".

- Medical and nursing staff spoke positively of each other and reported that working relationships were effective and supportive. However, there was some evidence of historical management–clinician divides that had never been 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.
- We met with staff on the interventional radiology unit and regional burns unit. Staff were clearly proud of their work and the high level of care they provided to patients. They had a clear understanding of the values of the unit and the management's vision in taking the service forward.

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.
- Ward-based patient satisfaction surveys were undertaken. For example, patients accessing physiotherapy services on the burns and plastics unit showed that 100% of patients would recommend the service to others.
- 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.
- Innovative practice was encouraged and we saw examples of projects that had led to changes in practice. For example, the urology department had been recognised nationally for the use of green light laser surgery, which is a minimally invasive procedure for prostate symptoms. The procedure enabled patients to return home within a few hours and return to normal activities within days.

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 Hospital. There are 25 beds in total, 15 at Pinderfields Hospital. This includes two beds providing specialist intensive care for patients with burns.

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

Summary of findings

We rated the critical care service at Pinderfields Hospital as good, but there were improvements required in some safety aspects. Generally nursing and medical staffing levels were safe. However, there was insufficient staffing on the acute respiratory care unit to meet with national guidance for the provision of Level 2 care.

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.

Critical care

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

There were effective arrangements for reporting safety incidents. There were reliable systems, processes and practices in place to keep patients safe. This included systems to ensure the cleanliness of the critical care unit and to reduce the risk of infection for patients.

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.

Generally nursing and medical staffing levels were in line with the 'Core Standards for Intensive Care Units'. However, staffing levels on the acute respiratory care unit on Gate 20, where care was provided to Level 2 patients did not meet the critical care core standards.

Incidents

- There were no never events or serious untoward incidents reported in the critical care service in the last 12 months.
- Incidents were 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.
- Staff knew how to report incidents and could describe a range of incidents they would report. They also told us they had feedback from reported incidents 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 unit 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 on '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 and 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.
- The infection prevention and control audit score for July 2014 was 100%, indicating that the critical care unit was fully compliant with relevant policies and procedures.

Environment and equipment

- The critical care unit was located in the new Pinderfields Hospital building. The environment, equipment and facilities complied with relevant government guidance for critical care units. Staff told us they were pleased with the facilities and equipment in the unit.
- There was a lack of suitable storage space within the unit. This had been identified as a risk and there were plans to address this.
- There was no scavenging system in the critical care unit. This would be used to give an anaesthetic to a patient in the critical care unit. This had been identified as a risk to patients and there was a plan in place to purchase new equipment.
- There was a programme in place for the regular maintenance of equipment. Staff told us that any repairs reported were dealt with promptly.
- We found checks of resuscitation equipment were carried out and recorded every day.

Medicines

- Medicines, including controlled drugs, were stored in a designated room in the critical care unit. The pharmacist support provided met the requirements of the core standards for critical care units.
- Entry to the room where medicines were stored was gained by using a key code door lock. This was not a fully robust system because the code could be observed by visitors or others not authorised to enter the room. The critical care pharmacist was aware of the issue and had assessed the security risk.
- 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

- Critical care standardised nursing documentation was kept by the end of the patient's bed. We reviewed three of these charts. Overall, we found 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.
- Each patient had a medication prescription and administration chart. We looked at five of these and all were completed correctly.

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, "The doctors and nurses explained what was happening and asked for my agreement. I know there were times when I couldn't tell them and so they asked my family."
- 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 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 matron and unit manager 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 intra-venous lines used to administer medicines and fluids.

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.
- The unit manager told us that occasionally patients under the age of 18 were admitted to the unit. On these occasions, there were arrangements for support from the paediatric doctors within the hospital, including paediatric anaesthetists.

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 in the critical care unit 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.
- The action plan following the March 2014 NEWS audit included the introduction at Pinderfields Hospital of a handheld electronic device for staff to use to record patient observations. Staff reported that the device was quicker to use, more accurate and reliable than a paper recording system. The device was already in use at Dewsbury District Hospital.
- Patients' records showed that individual risks were identified and monitored, such as the risk of developing pressures ulcers or blood clots or sepsis.

Nursing staffing

- The nurse staffing level in the critical care unit was in line with the core standards from the Intensive Care Society. This included the minimum ratio of one nurse to one patient for patients with higher critical care needs.
- The planned staffing level was 12 nurses per shift for 15 critical care beds. This was calculated by assuming nine patients would require one to one nursing and six patients would require one nurse between two patients. Information provided by the trust showed that the planned staffing level was achieved most of the time. The unit manager told us that patients' needs were always met by nurse staffing levels.
- There was a supernumerary nurse for each shift acting as a clinical coordinator. The responsibilities of the clinical coordinator included the organisation and supervision of nurse staffing to optimise the safety of patients.
- The planned nursing staffing was mostly maintained when not all beds were occupied. This meant that the nursing staffing level allowed for unexpected increased demands for critical care beds.
- Agency and bank staff were used to cover if necessary. We saw that the unit manager was able to specify when booking agency staff that they must have relevant training and experience in critical care.
- There were six (whole time equivalent) vacant nurse posts in the critical care unit. The unit manager told us there had been a good response to recruitment for these posts, and interviews were happening during our inspection visit.
- Nurses and healthcare assistants told us they were frustrated that they were sometimes moved to other wards to provide cover.
- During the unannounced visit on 27 July 2014 patients and staffing on the acute respiratory care unit (ACU) on G20 were reviewed. We found there were 8 patients with 3 qualified nurses. The Intensive Care Society Standards on the levels of critical care for adult patients (2009)

describe the levels of care required by critically ill patients in hospital. Level 2 patients are characterised by patients who require care for single organ support. For example patients who received basic respiratory support such as Bi-level positive airway pressure (BIPAP) would be classed as requiring level 2 care.

- When we asked one of the registered nurses on duty they described the patients on the unit as requiring level 1 care. However on further discussion there were 4 patients on BIPAP. We asked the nurse about these patients they told us the patients had been put on BIPAP as an acute intervention due to their conditions. Therefore this meant the nurse to patient ratio should have been 1 nurse to 2 patients in line with the critical care core standards.

Medical staffing

- The core standards from the Intensive Care Society were mostly met with regard to medical staffing in the critical care unit. The care was led by a consultant in intensive care medicine. There was a team of 12 critical care consultants who provided 24-hour cover, making consultant-level care and support available to patients at all times. The consultant to patient ratio was within the range of 1:8 to 1:15.
- The consultants' work pattern did not meet the core standard of consultants working five-day blocks of day shifts to provide continuity of care. Consultants we spoke with told us that there were plans to introduce block working later in 2014 at Pinderfields Hospital.
- Nurses and other healthcare staff we spoke with said they had no concerns about medical staffing in the critical care unit.

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 unit manager told us there had been practice responses to test the major incident policy. Lessons learned had been fed back to staff. Staff also told us about an incident in 2013 when the major incident policy was implemented.

Are critical care services effective?

Good

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.

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 received evidence-based assessment, care and treatment in line with recognised guidance, standards and best practice. For example, there was a daily ward round by the multidisciplinary team, led by a consultant in intensive care. This meant that the consultant had access to relevant information and could make timely decisions about the management of critically ill patients. This was in line with the core standards for critical care units and also with NICE guidance.
- Another example was the use of specific care bundles. 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. 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 also

monthly audits of all care bundles used. This was to ensure that all elements of the bundle were applied together as 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.
- A patient told us they had pain but this was being effectively managed. The patient knew the doctor had reviewed and changed their pain relief medication that day.

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) and dieticians. 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.

Patient outcomes
- Critical care services at Pinderfields 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 figures showed that the hospital mortality rate for the third quarter of 2013 was slightly above the normal range for the critical care unit at Pinderfields Hospital. The intensive care consultants had discussed this and there was ongoing work looking at possible causes and appropriate action.
- The ICNARC data for 2013 showed that the rate of unplanned readmissions to the critical care unit within 48 hours of discharge was 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 (WYACCOD). 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. This was from reported 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 and there was a team of appropriately qualified and experienced medical staff.
- Trainees in intensive care medicine were supervised by the consultants. The trainees had appropriate experience to work in the critical care unit and their training in the unit met the requirements of the Faculty of Intensive Care Medicine.
- 48% of the nurses working in the Pinderfields Hospital critical care unit had a post-registration qualification in critical care nursing. This was below the core standard of 50% of nurses with a post-registration qualification. This had been identified as a risk and there were plans for this to be addressed through recruitment. Overall, 52% of critical nurses working in the trust had a post-registration qualification in critical care nursing.
- 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.
- 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 unit had received an appraisal in the previous 12 months.
- 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.

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. Examples given included physiotherapists and speech and language therapists working together to assess

patients, and the involvement of microbiologists in ensuring the effective use of antibiotics. A therapist said, "There's a good, professional relationship with all nurses and consultants."

- Patients were sometimes transferred to the critical care unit at Dewsbury District 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 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 available at all times to offer consultant-level care to patients as necessary. There were daily consultant-led ward rounds seven days a week.
- 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. There was an on-call provision out of hours, though this was not always therapists specifically experienced in critical care.

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.

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.
- We spoke with three families about the care and support being provided to the patients. They spoke highly of the care provided. One family member told us, "The staff have been very good, very reassuring to (patient) and to us."
- Patients' privacy and dignity were maintained. Curtains were used around bed areas while care was delivered. A patient told us, "I was embarrassed because staff had to clean me, but they made me feel ok."
- 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.
- Cards and letters from patients and families were displayed in the waiting area. There were numerous positive comments about the compassionate care provided.

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 spoke with a patient recently discharged from the unit. They told us that, whenever possible, their care and treatment had been fully discussed and explained to them.
- Patients' families told us they had been kept informed of the care and treatment for the patient and of the patient's progress. A family member said there had been, "Plenty of phone calls to home – good communication." Another family member told us, "The doctors have taken time to make sure we understand what's happening. They're very good at explaining things."

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 and snack dispensing machines in the waiting area and three rooms 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.

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 Pinderfields 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 Pinderfields Hospital. There were agreements in place to ensure that these patients were returned to Pinderfields 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 Pinderfields 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 seven general intensive care beds and six acute high dependency beds
- There were six isolation cubicles within the unit. There were two burns intensive care beds in burns cubicles adjacent to the critical care unit and managed by the critical care team.
- The critical care unit did not admit patients who required level one care (sometimes called high dependency). The level of care was determined using guidelines from the Intensive Care Society, with level one patients typically requiring less complex care. Patients needing this level of care were treated in high dependency units elsewhere in the hospital, such as the respiratory high dependency unit. This meant that the beds in the critical care unit were available for patients requiring general intensive care (level three) or acute high dependency care (level two).
- Admissions to the critical care unit could be planned or emergency. Planned admissions were patients

undergoing elective surgery where the need for critical care had been identified and planned in advance. Emergency admissions could be from within the hospital or from other hospitals. Emergency admissions took priority over planned admissions.

- Admissions were based on clinical need and were always arranged through discussion with the intensive care consultant on duty.
- Information provided by the trust showed that average occupancy was around 78% during the period May 2013 to May 2014. The national average occupancy rate for critical care units 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 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 the number of patients discharged out of hours was, on average, around four a month. This rate was within a statistically acceptable range when compared with ICNARC data from other critical care units.
- 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.
- However, the ICNARC data for 2013 showed that the number of patient discharges delayed by more than four hours was worse than the Critical Reference Group (CRG) threshold. The CRG thresholds are used by ICNARC to define the standards expected in adult critical care units. Also, information provided by the trust showed a rise in delayed discharges in 2014. Monthly figures from August 2013 to January 2014 were low but then started to rise. The latest figures available were for May 2014, when there had been 20 delayed discharges during the month.
- Information provided by the trust showed that there were 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

- The local critical care network held informal social events for people who had used critical care services and their families. In response to feedback from one of these events, the wall clocks in the critical care unit recently had been changed. The new clocks were clearer and easier to read from patients' beds and also displayed the date.
- 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 multi-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 information in other languages.
- Complaints about the critical care unit were infrequent. The unit manager told us there had been one complaint in the last six months and this had been resolved to the complainant's satisfaction.

Critical care

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 Pinderfields and Dewsbury hospitals. There was a unit manager for the critical care unit at Pinderfields 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. One member of staff said there was, "Good team work", but felt that their concerns were not always listened to because managers were "Going through the motions" rather than properly addressing issues. Another member of staff felt that the management of the service had improved over the last two years.
- Staff were aware of the Chief Executive and the executive management team. Most staff had met the Chief Executive, though felt there could be more visibility of the Chief Executive and the executive management team at ward level.

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.
- Risks identified in the environment of the critical care unit had been assessed and action plans made were almost completed.

Culture within the service

- Medical, nursing, therapy and administration staff all reported good team working within the critical care service. Comments included: "It's a good place to work", "Everyone has been so friendly and helpful" and "I feel well supported by my manager".
- 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. A therapist felt the executive team were not visible enough and did not understand the pressures faced by staff, commenting, "They don't know what life on the ground is like." A common theme was the frustration felt by staff 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 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.

Critical care

- The Friends and Family questionnaires were used. However, the unit manager told us the questions were not really tailored for critical care and so the results were not 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 3843 births at Pinderfields maternity unit.

The inspection of Pinderfields General Hospital included the antenatal clinic, antenatal day unit (two en-suite rooms), triage which was open 24 hours a day, an antenatal and postnatal ward, four triage couches, delivery suite, two obstetric theatres and a four-bedded recovery ward. We spoke with 18 women who used the service and 32 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 15 sets of care records and reviewed the trust's audits and performance data.

The trust is reorganising their services and the reconfiguration of women's and children's services is due for completion in 2016. Pinderfields General Hospital's maternity department will increase in size to include more delivery rooms, antenatal and postnatal beds and a third theatre adjacent to the current maternity theatre suite. A new midwife-led unit will also be built on part of the hospital site, adjacent to the maternity unit and with separate access through a new link bridge.

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. Maternity areas were clean and there were effective systems in place to monitor infection control. There was an incident reporting mechanism in place and lessons learnt from investigations were shared. However, staffing levels did not meet best practice 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.

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

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, where the amount of blood loss was not considered significant, 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.

Cleanliness, infection control and hygiene

- We saw the trust had an infection control policy and evidence that it was reviewed. The maternity unit was 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, the use of hand gel and the bare below the elbow dress code.
- 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 equipment had stickers on it showing it had been cleaned and this included portable electrical equipment.
- The trust integrated performance report dated May/ June 2014 reported no incidents of MRSA or Clostridium difficile infections across the site between January and July 2014.
- We saw the noticeboard located outside the labour ward and antenatal clinic showed there had not been any MRSA or C. difficile infection 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 call button entry for mothers and visitors and swipe card entry for staff.
- We saw in the delivery suite that there were 11 rooms and records showed the resuscitation equipment trolley had not been checked daily in all rooms on a regular basis. For example, we saw one resuscitation equipment trolley had not been checked for five days, another had not been checked four out of ten days. This meant in the event of an emergency the appropriate equipment or medications may not be available to use or still within their expiry date.
- We saw equipment was available to meet people's needs, such as carbon dioxide monitors, piped oxygen and a cardiotocograph machine.

Medicines

- Medicines were stored and maintained correctly and appropriate checks were carried out. However, we found in the delivery suite that, although medication was stored correctly, staff had concerns that if they needed an emergency drug (which was currently stored in a locked refrigerator in a locked room), it was not readily accessible. Following discussion, staff told us they would carry out an assessment for the accessibility of this medication and look at a way to reduce the risk while maintaining the required regulation of the safe storage of medicines.

Records

- We looked at 15 sets of care records; we found they were in paper format and of a good standard of record keeping. When not in use we saw they were kept safe in line with data protection.
- We saw comprehensive care pathways, for example, those relating to bereavement and foetal loss.
- The trust carried out a record keeping standards audit in February 2014; an action plan was created to address the issues identified. A full audit is to be repeated in September 2014 and will check that the issues identified previously have been addressed.

Consent

- We saw evidence in people's records that consent was obtained before procedures took place, such as, before having a caesarean section.

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 we spoke with knew the procedure for reporting allegations or suspected incidents of abuse, including adults and children; they confirmed they had training.

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 94.44% of staff had completed venous thromboembolism training.
- Midwives reported a number of mandatory training modules took place online. Staff who attended the focus group said they had to complete the training in their own time; trust managers told us that staff got this time back. We were also told mandatory courses were booked for staff via their electronic staff roster (e-roster) and sometimes this was on their days off; these had been arranged with their consent and they were paid for their time.
- The trust had trainers in obstetric emergencies and the staff confirmed they had training every year and involved all members of the multi-professional team. An example of obstetric emergency training included cord prolapse.

Assessing and responding to patient risk

- The unit used the Modified Obstetric Early Warning Scoring (MOEWS) system and the National Early Warning Score to manage deteriorating patients. We saw in the records 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 one to one 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 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.
- Cross-site working or agency staff were used when needed to cover staff shortages, 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 (days) should have been a ward manager, a coordinator, six midwives, two healthcare assistant and a scrub nurse; there was one midwife less than the agreed

minimum safe staffing levels. There was no record on the plan to show an agency midwife had been requested and the shift had not been covered. Staff told us that although they covered between the trusts sites, this sometimes made Pinderfields short-staffed.

- On the day of inspection the antenatal/postnatal ward noticeboard showed staffing levels were 90% day and 90% nights; bed occupancy was 70%. We were told by staff this ward was under establishment figures for staffing by 2.2 WTE and they did use agency staff.
- The antenatal and newborn screening coordinator told us the quality assurance visit from National Screening was due to take place in November. The head of midwifery had agreed funding for a 0.8 WE, band 7 until November to help prepare for the visit. We were told the post was not a clinical midwife and would not affect the staffing ratios.
- Figures provided by the Local Supervising Authority of their annual audit report, 'Monitoring the Standards of Supervision & Midwifery Practice' (October 2013) gave the ratio of supervisors of midwives to midwives as 1:16, 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. Staff also told us they had not experienced problems accessing a supervisor of midwives.

Medical staffing

- Consultants covered the labour ward Monday to Friday between 9am and 8pm (11 hours a day). On Saturday and Sunday cover was three hours a day (on-site) and on-call out of hours. This complied with the Royal College of Obstetricians and Gynaecologists guidelines. We were told a consultant saw patients each day and carried out regular daily ward rounds.
- Junior doctors told us out-of-hours consultants were contactable. Staff were managing the unit well and they had no concerns with patient safety. We were told by doctors that team working was good.
- We were told senior house officers (doctors) covered triage, gynaecology, accident and emergency and labour ward when they were on call. We were also told that due to women experiencing long waits in triage, a separate senior house officer had been allocated to cover the triage area.
- 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.
- We were told the anaesthetic service had experienced difficulty in covering consultant presence on the labour ward from 8am to 6pm Monday to Friday. This was because of staff not being replaced after retirement and the money saved was used as cost savings. The reconfigured maternity services will need fewer consultant anaesthetists when the changes are implemented, but the lack of replacement had led to shortages in the last two years. Staff grades had been used to cover, but after a serious incident there was now cover from other consultant anaesthetists who were not specialised in obstetric work. This had led to general operating lists being cancelled to provide appropriate cover on the delivery suite.

Nursing and medical handover

- We observed staff handovers on the delivery suite and these occurred twice daily. Staffing for the shift was discussed as well as any high-risk patients and the impact on the unit.
- A Situation, Background, Assessment, Recommendation transfer record was used when handing over care between staff. This was also used 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 staff were moved between sites to meet 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 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 to help organise the team better in the event of an emergency.

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 a combination of NICE and Royal College of Obstetricians and Gynaecologists guidelines (RCOG). For example, RCOG in the management of shoulder dystocia.
- Practice is audited against these standards and forms the basis of the National Health Service Litigation Authority (NHSLA) standards for maternity care.
- The trust provided us with examples of audits carried out during the year, which included using the National Early Warning Score to monitor deteriorating patients. The audits of these records for July 2014 showed they had been completed appropriately.
- 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 Pinderfield maternity unit was: 3843. Of these births there was 232 (8.6%) elective caesarean sections and 550 (14.3%) emergency caesarean sections which was in line with the national averages.
- There had been four neonatal deaths between June 2013 and May 2014.

Maternity and gynaecology

- 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 (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.
- Antenatal clinics were also attended by specialist midwives such as the drug liaison midwife and the young women's midwife, and clinicians such as a registrar specialising in diabetes had a weekly clinic providing joint care and support for patients with diabetes.
- We spoke with a police officer in relation to multidisciplinary working and keeping people safe from harm. They spoke positively about the police relationship with the trust in protecting people.
- Staff reported that midwives and doctors worked closely and the consultant staff were very approachable and supportive.

Seven-day services

- Consultant Obstetricians provided cover Monday to Friday between 9am to 8pm (11hrs per day).Saturday and Sunday cover was 3 hours per day (on site). This complied with RCOG guidelines.
- We found the service had access to a pharmacy services when needed.

Are maternity and gynaecology services caring?

Good

Pinderfields maternity unit 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. We saw letters and cards of appreciation and positive comments about people's experience of the unit.
- During labour we found women received one to one care and support 98% of the time.
- We were told that when a woman had a medical termination of pregnancy they were cared for in the bereavement room on the antenatal ward. If the antenatal ward was not able to provide one to one support, the person would be transferred to the labour ward where the care would be provided.
- 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). For women having skin-to-skin contact (baby naked, directly on their chest or tummy) with their baby shortly after the birth, the trust scored 9 out of 10 in the national survey (average compared with other trusts).

- We observed women being treated with compassion, respect and dignity. However, we did observe one incident on a ward where a staff member was using the telephone and discussing confidential information where people could hear. This was brought to the attention of the ward manager and they addressed the issue with the person at the time.
- The trust scored 9 out of 10 in the national survey for women being treated with respect and dignity during labour and birth (average compared with other trusts).
- 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 stated they had been involved in decisions regarding their choice of birth and were informed of the risks and benefits of each. They told us they felt involved in their care and supported by staff.
- In the national survey completed 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. The midwife was trained in cognitive behaviour therapy. A pre-conception, 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 innovative 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. 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.
- The reconfiguration of women's and children's services was due to be completed in 2016 and would provide a service to meet the needs of the local population. All women booked for consultant-led care will attend Pinderfields Hospital, and Dewsbury will be developed into a midwife-led unit.

Access and flow

- With the exception of midwifery managers and obstetric consultants, 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. Staff told us the flexibility was working well. They initially were concerned about working at other sites and now found they didn't mind.
- The lead midwife and ward manager told us triage was relocated and managed from the antenatal ward, however this was currently being looked at with a view to relocate it to labour ward.
- The lead midwife and labour ward and theatre staff told us there were two elective theatre lists each day and emergencies took priority over the elective lists. This sometimes caused long delays to women booked on the list as to when they were able to go to theatre.
- 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.

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.
- 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; including information leaflets in different languages to assist people whose first language was not English in communicating.

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 has 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. Pinderfields General Hospital will become a consultant-led/ midwife-led unit and Dewsbury Hospital will become a midwife-only-led unit like Pontefract. 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 managers in the last five years, with more changes planned in the near future. The change in Head of Midwifery had been sudden, but staff expressed optimism for the future with this move and had already seen positive changes.
- One person told us they received good support from the trust's personnel department and felt well supported by the service's management.
- Staff reported seeing their line managers regularly, but 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 told us they felt listened to and supported by their line managers. They also told us, although it was 'early days', the new head of midwifery (who was also a consultant midwife for normality) was very supportive and made a big impact on staff, and they were hopeful the culture would change. However, because this midwife was also a consultant for normality, the staff were concerned they may be expected to take risks that could be against guidance and they were worried they would be disciplined as a result. The staff survey showed staff felt underappreciated. We were told actions had been implemented, with additional staff being recruited and increased communication, so there was now a very different culture. Staff told us local leadership was good. Staff told us they would recommend this unit as a place to work.
- Some staff told us they felt listened to and supported by their line managers. Staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service.
- In March 2014 women's services were placed into one directorate. We could not fully establish how open the culture was within the leadership team, because we had mixed messages about their openness from staff.
- Staff told us the new head of midwifery was very supportive and staff were hopeful the previous unsupportive culture would change. 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."

- Staff told us the executive team were only visible because the CQC were inspecting. When we inspected one ward with a senior manager who had been appointed in the last few months, staff asked the person (senior manager) who they were.

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.
- The MSLC consists of a group of lay and professional people who meet regularly to discuss local maternity service provision. Mid Yorkshire is served by two MSLCs, one based in Wakefield, the other in Dewsbury, serving different demographic profiles. Senior staff demonstrated good engagement with the MSLCs and identified areas where innovative work was taking place to improve engagement with low socio-economic groups through liaison with existing support groups.
- 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 deadline and reminded staff to complete the staff questionnaire to provide a snapshot of how they were feeling at a given moment in time.
- One staff told us the consultation for the reconfiguration was short and initially not everyone was consulted or listened to about the proposals.

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 19yrs 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 3 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 years and over), therapy services and neonatal services.

Gate 46 provided 24 children's inpatient beds for medicine and surgery along with additional weekday beds for day surgery. Five of these beds were regional burn unit beds located in a dedicated area within the cluster areas of gate 46. There was an eight-bedded child assessment unit co-located with the emergency department that accepts admissions from the emergency department and from general practitioners. The children's centre located adjacent to the main entrance included a children's outpatient department and children's therapy services. The neonatal/special care baby unit (SCBU) located adjacent to the maternity area included four intensive cots, three high-dependency cots and eight special care cots.

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 Pinderfields Hospital we visited the child assessment unit, the children's outpatient department, gate 46, the burns unit and the neonatal/ SCBU unit. We talked with five medical staff and 21 nursing and allied healthcare professionals, and examined 15 medical/nursing records. We spoke with 15 children and parents.

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, although staff did not always receive feedback on reports. At ward and division level risks were regularly assessed and monitored, with control measures in place. However, we found there was confusion over version control on risk registers.

Staffing levels across all children's services did not always meet national best practice guidance.

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. 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. 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 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. We found there was confusion over which was the current version of the risk register. However, there was no nominated executive and non-executive director at board level to champion children's rights.

Are services for children and young people safe?

Requires improvement

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms. Staff on the children's and neonatal inpatient services told us they did not routinely receive feedback about incidents they had reported to the trust. 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 gate 46 and the burns unit was spacious, well lit, uncluttered and had a range of facilities for children. The neonatal/SCBU unit was cramped in comparison with gate 46. The corridor linking the bays was narrow, dull and uninviting. Facilities for members of staff were poor on this unit. The staff rest area was a converted small milk room with little natural light and little space to sit, stand or move around and staff had to share a changing room with an adult respiratory ward, which was located away from the unit.

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 demonstrated an awareness of how to safeguard children. The hospital did not hold pre-assessment clinics for elective surgery, which meant consent was most commonly recorded on the morning of surgery. This meant 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.

We found a mixed picture regarding staffing within all clinical areas of the inpatient children's services. Staff reported they had staffing shortfalls at times within the child assessment unit, gate 46, children's burns unit, children's outpatient departments and neonatal/SCBU unit. 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 how they could access additional staffing and support during clinic sessions. Staffing on some spans of duty may not always meet national best practice guidance.

Incidents

- Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms. Sisters on all clinical areas felt their staff were good at reporting incidents. Staff told us on the children's and neonatal inpatient services they did not routinely receive feedback about incidents they had reported to the trust. This included more senior members of nursing staff, including band six and band seven sisters. This meant staff were not always made aware of how the incident had been investigated and where learning from the incident had taken place.The trust informed us the incident reporting system provided electronic feedback on the outcome of the investigation to the reporter.
- 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.
- There had been one serious untoward incident reported that involved a child within the last 12 months (not within the children's ward or outpatient services). The head of clinical service and group manager outlined how the incident had been jointly investigated by the paediatric consultant team and the emergency department. We reviewed the root cause analysis investigation, which showed that the investigation had identified root causes of the incident, recommendations and how learning would be disseminated to relevant parties.

Cleanliness, infection control and hygiene

- We found the child assessment unit, gate 46, children's burns unit, children's outpatient department and the neonatal/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 throughout our inspection of all clinical areas.
- Nursing staff were very complimentary about the regular domestic staff that cleaned gate 46 and other areas.
- We were told that regular hand hygiene audits and infection control audits were undertaken in the various clinical areas. For example, we reviewed a completed infection prevention audit tool for the child assessment unit completed on 11 July 2014 that demonstrated a detailed audit had been undertaken and recommendations made where required. The neonatal/SCBU area 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 gate 46 and the burns unit was spacious, well lit and uncluttered. The area had a range of facilities for children, young people and families. For example, on gate 46 there was a large spacious play area and a designated school room. Bed areas in both cubicles and bay areas were spacious. Additional facilities had been developed to meet the individual needs of children, for example, a 'chill room' had been introduced for adolescents.
- Gate 46 was split into two clusters that were regularly used (B and C); along with the rarely used cluster A (which led to the children's burns unit). Staff explained there was an issue with the emergency buzzer system that meant if the buzzer was activated within B cluster area, staff could not hear the buzzer in C cluster. This meant staff may not be able to respond and support staff in an emergency. A risk assessment had been completed that identified that the separating fire door between B/C clusters should be kept opened (this automatically closes during a fire alert) so that staff may

hear the emergency buzzer. This meant there was still a potential risk of staff not being adequately supported during a clinical emergency during any period when the door was closed.

- The neonatal/SCBU unit was cramped in comparison with gate 46. Facilities for members of staff were poor. The staff rest area was a converted small milk room with little natural light and little space to sit, stand or move around. Neonatal staff currently had to leave the unit to get changed in a cluttered room that was shared with members of staff from the adult respiratory ward. Neonatal staff told us they had been issues around the security of personal items in this area and were concerned about sharing the changing room for infection prevention reasons.
- 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 reviewed a sample of treatment records on gate 46 and observed the administration of medications. 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

- Each of the clinical areas we visited had a ward clerk/ administrative staff 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

- The children's service operated a day surgery bay within cluster C area of gate 46. Elective and emergency surgery were performed at Pinderfields Hospital. The hospital did not hold pre-assessment clinics for elective surgery, which meant consent was most commonly recorded on the morning of surgery. This meant 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. Parents we talked with whose child was having day surgery told us they had received information about the surgery before signing the consent form.
- We reviewed a sample of five records where consent had been obtained before surgery and found these had been appropriately completed, dated and signed by the doctor/surgeon and parent.
- 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 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 gate 46 and the burns unit showed 100% of staff working in the department had received level-three safeguarding training within the trust's expected timespan of every three years.
- We talked with one junior doctor who told us they had not received any form of safeguarding training. We asked the children's management team to investigate. The management team later confirmed the junior doctor had received safeguarding awareness training through the trust's induction processes.

Mandatory training

- Members of staff of all grades confirmed they received a range of mandatory training. This included staff from the child assessment unit, children's outpatient department, gate 46/burns unit and the neonatal/SCBU unit. We checked records that confirmed staff uptake of mandatory training was maintained to a good standard.
- On gate 46 we reviewed how mandatory training was delivered in more detail. The band seven ward manager had a structured system in place for training. The nursing staff were split into four teams, led by a band six sister. Each sister was responsible, along with the staff member, for ensuring they completed mandatory training within defined timescales.
- We reviewed a detailed training record for gate 46, which showed good levels of compliance. For example, moving and handling training was currently 95% and staff whose training had expired were booked to attend a training session in the near future.

Assessing and responding to patient risk

- At a local level the children's service managed local clinical and environmental risks appropriately. For example, on gate 46, one of the band six sisters supported by the band seven sister had completed a number of local risk assessments and reviewed them regularly. The risk assessment for the 'insertion of cannula' had been reviewed and included appropriate control measures to manage the risk.
- However, we identified one local risk assessment relating to staffing at night for B and C clusters on gate 46. We reviewed the risk and saw that the score appeared low when assessed using the risk rating matrix. We asked the children's management team to re-assess this risk assessment so that it would accurately reflect the risks identified.

Nursing staffing

- We found a mixed picture regarding staffing within all clinical areas of the inpatient children's services. Staff reported they had staffing shortfalls at times within the child assessment unit, gate 46, children's burns unit, children's outpatient departments and neonatal/SCBU unit.
- The structure and staffing of gate 46 was complex, in part because the large spacious environment was split into clusters. Gate 46 was a 24-bedded general children's ward caring for a mixture of medical and surgical patients. Five of these beds were allocated to the children's burns unit, which was a physically separate unit located off the unused cluster A of gate 46. In addition, there was a large bay used on week days for day surgery, which was staffed by gate 46 staff but not counted as part of gate 46 staffing numbers.
- Staff on gate 46 generally felt staffing on the day time shift was 'okay' most of the time. We reviewed daytime staffing and found this was adequate. Expected minimum staffing for gate 46 daytime shifts was six registered children's nurses supported by two healthcare assistants. This would meet the RCN guidelines published in 2013 for the staffing of children's wards.
- However, members of staff of all grades told us they were concerned about staffing levels at night on gate 46, in part because of the large spacious environment and the physical distance between the nurse stations located on B and C clusters. Regular staffing numbers at night included four registered children's nurses (two for each cluster). There was some distance from the medical area B cluster nurse station and the treatment room, which was located on the C cluster corridor. Staff explained that one nurse from each cluster would perform medication checks, which left two nurses

working alone at B and C clusters for a period of time. A risk assessment had been completed by a sister and the ward manager about night staffing risks, although we were concerned that their moderate concern rating had been reduced by a more senior nurse manager.

- In addition, we were told staff breaks at night on gate 46 should be covered by the healthcare assistant working on the burns unit. When the healthcare assistant left the burns unit to cover staff breaks on gate 46, it would leave one registered nurse alone on the burns unit, which was physically separated from gate 46 by cluster A and two closed fire doors. Potentially, if each registered nurse took their full entitlement to breaks, it would mean the five-bedded burns unit would be staffed by a single registered nurse for four hours, which would place the nurse and patients at potential risk. We could not establish how well the current arrangement worked.
- Staffing on the children's burns unit at night fell below the standard set out in the 'National burn care standards' (2013), which requires a minimum of two registered children's nurses on duty at all times.
- Staffing generally on the burns unit had little inbuilt flexibility to cover staff who required annual leave, maternity leave and study attendance. During the day time there were two registered nurses, but these staff also managed burns outpatient attendances on the unit. We were told these attendances were often time consuming because children required bathing and other care as part of the dressing changes.
- The neonatal/SCBU staffing varied, depending on the number of babies on the unit and the dependency level of care they required. We reviewed staffing on the neonatal unit in more detail and found there was limited flexibility in the establishment to adequately cover busy periods. Three band six sisters raised concerns about the staffing of the high-dependency neonatal cots, which required nurses who were "neonatal nurse qualified in speciality" (QIS) with a recognised neonatal course.
- A review of duty rotas showed band six QIS staff and band five QIS staff regularly worked additional spans of duty to ensure adequate numbers of staff were available to meet the needs of high-dependency level-one and level-two babies. Despite the additional cover, some spans of duty still fell below the nationally recognised British Association of Perinatal Medicine staffing standards.
- We focused on the duty rotas from 23 June 2014 to the time of the inspection. Each of these rotas included existing staff members working additional spans of duty on top of their existing contracted hours. Some duties were covered by agency staff. Staff showed us several examples of shifts where cover did not fully meet national guidelines. For example, on 13 July 2014 the day shift had three level-one babies requiring one to one care from a QIS nurse, four level-two babies requiring care and/or oversight from a QIS nurse and 10 level-three babies requiring special care. The unit was caring for 17 babies, two over the 15 cots normally open. On duty were four nurses QIS trained, one staff nurse not QIS trained, one staff nurse (part time 7am to 1pm) and one healthcare assistant. This meant staffing fell below required national guidance because some of the QIS nurses cared for more than one intensive/high-dependency baby and there were insufficient staff to care for the special care babies, which would require one nurse for every four babies.
- 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 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 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.

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 we talked with 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 service's 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 evidence-based practice, for example the introduction of carbohydrate master classes for children with diabetes following a diabetes peer review.

Services for children and young people

Pain relief

- 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 pain scoring tool was incorporated into the PAWS assessment tool that was completed by members of staff. On one record we found a child had been in pain through discussion with the family, but the pain section on the PAWS chart had not been completed.
- 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.

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 the housekeeper. We were told there was not a specific children's menu.
- When possible, children were encouraged to eat meals in the dining room area on gate 46 and the inpatient areas operated a protected mealtime's policy.
- On gate 46 there was a dedicated milk kitchen and facilities available so that parents could make up their own baby milk within their babies' preferred bottles.

Patient outcomes

- We reviewed information that demonstrated children's services participated in national audits that monitored patient outcomes, when 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. We reviewed a sample of the books on gate 46 and saw these were used by parents and comments were very positive about the care received. 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 90% of gate 46 and burns staff had received an annual performance development review (appraisal). Where staff had not received an appraisal, a date for completion had been recorded on a tracker. 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 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 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.
- The children's service had its own physiotherapists on weekdays, who also had their own spacious fully equipped physiotherapy room located on gate 46.
- 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.
- Staff also told us children's services worked closely with nominated children's lead surgeons and doctors in specialities such as emergency medicine, ENT, orthopaedics, general surgery and anaesthetics.

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.
- However, staff told us there were often significant delays during the weekend when discharging orthopaedic patients because they had to wait for a discharge review by the orthopaedic doctors. Similarly, delays to orthopaedic patients may sometimes occur because the physiotherapist on call at weekends was not available to teach mobilising on crutches to the child and parent.

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. They felt they were fully informed and involved in decisions relating to their treatment and care. We spoke with 15 children and parents at Pinderfields Hospital who provided examples of how they had been provided with supportive care, sometimes beyond what they had expected. We observed that the play specialists and other 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 or escorting them to the operating theatre.
- The environment was warm and welcoming in all of the children's and neonatal areas. For example, there was a lively 'party' in the schoolroom on gate 46 one morning. There were facilities available to assist staff in ensuring the child and family's privacy and dignity had been met.
- We spoke with 15 children and parents at Pinderfields Hospital who 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. We reviewed a sample of the books on gate 46 and the neonatal/SCBU and saw comments were very positive about the care they had received. On the child assessment unit the staff used green, yellow and red bottles to gain children's views: the child placed a large Lego brick in one of these bottles to rate their stay on the unit.

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 15 children, young people and parents/carers during our visit to the children's areas at Pinderfields. We were told by a number of people that they had felt fully involved in the planning and decisions relating to their care.

Services for children and young people

- 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.

Emotional support

- Parents and children told us they had been well supported during their visits to the children's areas.
- We observed that the play specialists and other staff were responsive and supportive to a child's emotional needs.
- Parents gave examples of how staff supported their children. For example, one parent explained how supportive staff had been in various situations regarding the management of their child's diabetes.
- A play specialist was able to provide a positive story about how a child with autism and their family were supported on the child assessment unit.

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. Based on discussion and review of documentation, we found there was a lack of clarity on the potential responsiveness of service delivery after the implementation of the changes about to take place. This was because it was not clear if there were going to be additional beds provided at Pinderfields Hospital on gate 46 during busy times and how staffing would change to meet potential demand.

We found the children's service at Pinderfields 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 Pinderfields provided good access and flow to its services. There was a 12-bedded child assessment unit located adjacent to the emergency department. The unit accepted referrals from the emergency department and from general practitioners. Following assessment the child was either discharged admitted to gate 46 or kept on the unit for up to 24 hours.
- On gate 46, beds were suitably arranged into specialities. Cluster B focused on paediatric medicine and cluster C focused on children undergoing

emergency and elective surgery, along with some medicine. Within cluster C there was a dedicated bay for children undergoing day surgery that was staffed separately when open. We saw that nursing and medical staff worked closely between the clusters and day surgery areas.

- 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.
- We saw that facilities to meet children and young people's needs were sometimes limited in areas that saw mostly adults. For example, in the x-ray department there were very limited facilities available for children, with no toys or books. The x-ray department can call on paediatric staff or play therapists for support if required. The x-ray department use assessment play therapists if required and children do not wait for long periods.
- Gate 46 did not have an adolescent bay or ward area. However, we saw that the ward did take account of adolescents' needs. For example, following feedback from a young person, fundraising had taken place that paid for the furnishing of a "chill room" for adolescents. The room was spacious, well-furnished and equipped to meet teenagers' 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.

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 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 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.

Services for children and young people

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. The openness of the culture of senior leadership was less clear.

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.
- 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.
- The children's service managed ward and unit clinical and environmental risks appropriately. For example, on gate 46, one of the band six sisters, supported by the band seven sister, had completed a number of local risk assessments and reviewed them 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 the various children's wards, neonatal/SCBU and other departments, which was well organised. For example, on ward 46 the band seven ward manager was supported by four band six sisters. Each sister was 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 we talked with on all children's clinical areas spoke highly of their respective ward/unit managers along with the band six sisters for more junior staff. We directly observed a good standard of leadership at ward/unit level regarding the day-to-day management and organisation of the clinical area.
- At Pinderfields there was a band seven ward manager for gate 46 (including the burns unit) and the child assessment unit. The children's outpatient departments were managed by the ward manager for the children's areas at Dewsbury. The band seven ward manager for Pinderfields' neonatal unit also carried day-to-day management responsibility for Dewsbury Hospital's SCBU unit. Band seven sisters were supernumerary, although we were told they regularly maintained clinical skills (often to cover where staffing was 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. The majority of band six sisters were aware of the leadership team and about the roles they performed to a greater or lesser extent.
- 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 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, although staff did not feel that they had received enough clear information about these changes.
- We could not establish how open the culture was within the leadership team, in part because the testimony of four different members of staff gave two examples of negative actions in relation to an open reporting culture at the trust. Two members of staff on the neonatal/SCBU told us a member of the children's leadership team had told them not to bother submitting incident

forms about staffing shortages. On gate 46 we heard that the same member of the children's leadership team had told two other staff members to lower the risk rating of a local risk assessment relating to staffing. We were not able to corroborate these concerns, but they were made independently of each other. We asked the head of clinical service and group manager directly if any of the leadership team had ever asked members of staff to alter risk ratings and they confirmed they were not aware of any such request. The group manager confirmed that all staff should report staffing concerns using the incident reporting processes.

Public and staff engagement

- Comments books had been recently set up to gain children, young people and families' views of their experiences. We reviewed a sample of the books on gate 46 and the neonatal/SCBU, and saw comments that were very positive about the care people had received. On the child assessment unit staff used green, yellow and red bottles to gain children's views. The management team had yet to decide how they would formally collate and review comments received using the books.
- There was evidence that demonstrated children and families' views were listened to and acted on. On gate 46 there was a colourful wall board entitled "You said, we did." The board included comments from the last few months where action had been taken to address suggestions. For example, one comment bubble stated some young people were unhappy that there was no space away from younger children. In response, a fundraising event took place that paid for the creation of a chill room for young people.
- 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 and Pinderfields. We were told about a partnership forum involving three parents regarding the development of an ADHD (attention deficit hyperactivity disorder)/ASD (autism spectrum disorder) pack for families.
- 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.
- We were told by a representative of the local Healthwatch in the Wakefield area that they had recruited a young Healthwatch team aged 16 years and over. The representative explained the trust had been very supportive and were shortly to provide some training to the young Healthwatch volunteers so that they could perform visits to the emergency department and other areas where children attended.
- 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.
- Some staff recalled seeing different members of the trust board visiting the clinical areas. For example, we were told the Chief Executive had recently spent a period of time working with staff on the children's burns unit.

Innovation, improvement and sustainability

- The head of clinical service told us there were "pockets of innovation" with 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 Pinderfields 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 relatives. We also spoke with 16 staff, including: the specialist palliative care team, ward nurses, doctors, consultants, 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 decsions 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.

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 delays in reporting, 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.

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.

Risks to patients were not being monitored effectively. Some wards updated and responded to risks well but on other wards there was poor review processes in place which meant risks were not being responded to.

There were systems in place to monitor hygiene standards and staff adhered to good infection control practices. There were not always robust procedures in place to inform mortuary staff of potential infection control risks.

There were insufficient numbers of nursing staff available to ensure patients at the end of life received safe care. This impacted on patients care needs being met and staff access to training.

Incidents

- Staff knew how to report incidents and gave us examples of the types of incidents they had reported.
- We saw reportable incidents recorded in patient's notes. Some of these had been reported on the incident reporting system but others had not been. Staff told us the pressures of work affected the timeliness of incidents being reported and we saw examples where this had occurred. 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.
- One incident report form indicated a patient's records had not been sufficiently completed. Despite an incident form being submitted no action had been taken to rectify this. Incident reports from the mortuary showed a range of incidents had taken place.

End of life care

- Two reoccurring themes had been identified. The first was that mortuary staff were not always protected from the risk of infection as ward staff had not followed correct procedures. The second theme was where errors had been made or insufficient identification had been available to identify patients who had died. The outcome to incident investigations reported staff involved in the incidents were made aware of the findings but no trust wide learning was recorded to prevent reoccurrences.

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.
- We visited three wards during our visit. Information on the boards indicated that the planned staffing levels were frequently not being met.

Cleanliness, infection control and hygiene

- Ward areas and equipment appeared clean and we saw staff regularly wash their hands and use hand gel between patients. Bare below the elbow policies were adhered to. Information on how each ward adhered to this was displayed near the entrance areas. There were stickers on equipment to show when it was last cleaned.
- 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 staff may not be taking suitable measures to protect themselves from the risk of infection.
- We found that there were issues over the management of soiled and contaminated linen. Some of the linen used when relatives viewed deceased patients was stained and red bags of potentially infected linen were observed left on the floor, increasing the risk of the spread of infection. This could mean deceased patients and their relatives were not treated with dignity and respect.
- Audits and checks of hygiene standards in the mortuary were in place. Where deficits were identified an action plan had been drawn up. This had been discussed with staff and progress notes showed how the plan was being implemented.
- Cleaning of the mortuary was contracted out to a private company. The manager told us there were systems in place to escalate any concerns about the cleaning standards in the mortuary. They gave us examples of this and how this had been used to improve hygiene standards.

Equipment

- Staff reported equipment required to care for patients at the end of their life was available whenever it was needed. This included appropriate syringes to deliver sub-cutaneous medication.

Medicines

- The National Care of the Dying Audit (May 2014) reported the trust had symptom control guidelines for end of life care which were reviewed regularly.
- Anticipatory end of life care medication was appropriately prescribed for patients. This aimed to provide symptom control and pain management.
- We saw in one case where the patient's medication record was missing, staff did not take action to get the prescription rewritten. This resulted in some medications not being given at the prescribed time; including antibiotics and pain relief medication. The missing record and lack of medication caused some distress to the patient. The patient subsequently experienced pain and a doctor was called to rewrite the prescription. This meant the pain relief management plan had not been followed and as a result the patient experienced pain and discomfort.
- One patient told us of an incident where they had refused medications but staff tried to give them the medication without their consent. This was reported as an incident and was in the process of being investigated.
- Where patients had allergies these were recorded on their records and this was identified on their wrist bands so staff were aware of this.

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 trust between August and October 2013 but excluded maternity and intermediate care. A total of 37 wards were checked across the trust with 148 DNARCPR forms being assessed. 57% of the wards at Pinderfields Hospital were assessed. 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 onto detail recommendations across most aspects of the DNACPR processes including standardising documentation, handover documents and communication.

- We looked at 20 DNACPR forms throughout the ward areas. We saw there were variations in the completeness of the forms across the hospital.
- 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 the transfer of medical responsibility. We saw this was happening in some cases but not all. Therefore there were inconsistent practices being followed.
- 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 saw that most DNACPR forms had been completed where patients and families had been involved in the decision not to resuscitate. However, we saw two DNARCPR forms where there were no recorded discussions about whether the decision had been discussed with the patient or their family. We saw one DNACPR form for a person with learning disabilities, where the first two medical reasons given were "paraplegia, learning disabilities". Other reasons included in the notes were "spinal cord compression" and "infarct" (this was almost illegible).
- On one ward there was a system for filing care records but the matron reported that staff did not use this. This meant that it was not easy to find records and there was an increased risk of records being lost.

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, we found staff showed a poor understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. Staff recognised 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's 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 of advice and support to the wards on these issues.
- Training was delivered by the liaison nurse and the Adult Safeguarding lead nurse. 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 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 show 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 spoke with staff about their knowledge about the Power of Attorney. Staff had poor knowledge of this and told us they did not ask patients or their families if there were any 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.

End of life care

- A leaflet 'Consent to examination or treatment' was available, this was updated in 2011. The leaflet did not refer to the Mental Capacity Act 2005 or describe what steps would be followed if a patient was considered to not the ability to give consent.

Safeguarding

- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults.
- 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, although these were not hospital site specific.
- 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 trust's 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.
- On some wards the risk assessment tools were consistently reviewed and updated on a regular basis.
- On other wards there was infrequent review. We saw in one patient's record that an initial tissue viability risk assessment had been completed indicating there was a risk of tissue breakdown. Change had occurred and notes recorded changes to the patient's skin, which indicated breakdown of tissue and dressings had been applied. The records for the patient indicated there had not been any review of the risk assessment for 12 days.
- Body maps were used by staff to record any marks or wounds on patients' bodies. We saw some of these completed but they lacked dates so it was not possible to establish which were current and relevant to the patient's care.
- Staff regularly recorded National Early Warning Scores (NEWS), these were a recognised early warning tool being used to identify when patients were deteriorating. On some wards an electronic recording system was being piloted, this automatically alerted staff if there were elevated risk factors. We also saw paper versions of the NEWS tool. These were regularly completed at different intervals according to assessed patient need.

Nursing staffing

- Agency and bank nurses were frequently used to fill gaps on staff rotas. However, in most wards we visited the planned number of nurses who should be on duty was not being achieved.
- The nursing staffing levels were impacting on patient care. This included delays in receiving pain relief and delays in patients being supported with personal hygiene needs. On one ward patients were still being assisted to wash after lunchtime. One relative told us that there were delays in staff answering call bells.
- Staff told us that they sometimes did not get breaks, this particularly affected night staff when there were fewer staff on duty. One relative told us staff were always, "Rushed off of their feet".
- Staff told us that there were ongoing issues with unfilled staff vacancies throughout the hospital. There was an on-going recruitment campaign and some staff had been recruited but had not yet started at the trust. Most staff were optimistic that staffing levels would improve when staff commenced in post.
- Each ward had a lead nurse for palliative care. Whilst there had been some meetings held in the past, the lead nurses had not met for some time. This was attributed to poor staffing levels which did not allow staff to have time away from the wards. This meant the opportunity for any learning and updates in practice changes would not be consistently available to staff caring for patients on wards at the end their life.

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Medical staffing

- The care of each patient was managed by the consultant within the speciality 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.
- Should a major incident take place locally there were written guidelines in place to describe the role and remit of the mortuary staff.

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 palliative 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 developed 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 but these were core plans, which lacked any detail regarding the patient's individual care needs.

Pain relief was prescribed and levels of pain monitored but there had been occasions when there were some delays in this being given to patients.

Use of National Guidelines

- 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 they sometimes had to wait for pain relieving medication when they asked for it as staff were busy. Patients also told us staff were always busy and worked "really hard" but there were not enough of them. One relative told us they had waited an hour for an injection to be given to the patient as there were insufficient staff on duty. This meant potentially patients could be waiting significant periods of time in pain while they waited for their medication.
- Some medications required two nurses to check and give the medicines, staff told us as there were fewer nurses on duty than was planned this had the potential to affect the timeliness of medicines being given.
- On one ward staff told us medicine rounds could take up to two and a half hours. This was attributed to the lack of nurses who were available to give medicines. This meant that medications may be delayed or the time interval between doses may be affected as further medicine rounds were started within a short space of time as the previous one finishing.
- Patients told us that staff asked them regularly if they were in pain and medication was offered if they reported they were in pain.
- Some records indicated that patients were reporting pain but this was being recorded on the pain assessment record as a '0' score. Therefore robust and accurate recording of patients pain levels was not being completed.

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. On some wards these were reviewed regularly. On other wards the risk of malnutrition was not regularly assessed.
- We saw that on some wards there was consistent and accurate recording of patient's fluid and nutritional intake but this was not completed on all wards.
- Specialist speech and language therapy and dietician support was available across the wards. We saw examples where referrals had been made. The specialist advice given was recorded and implemented.

End of life care

- We saw that some patients who were unable to eat and drink safely were receiving intravenous fluids and/or fed by tube to maintain their nutrition and hydration.
- The trust had participated in the National Care of the Dying audit (May 2014). The results showed the trust was identified as being below the national average at reviewing nutrition and hydration at the end of life.

Patient outcomes

- The National Care of the Dying audit (May 2014) results showed that overall, the trust performed well in comparison to other trusts. The trust was identified as being below the national average at spiritual care and documenting care after death.
- Patients and relatives were complimentary of the care they received. 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 were not enough staff to allow for staff training to take place.
- Some staff told us that the Liverpool Care Pathway had been withdrawn but they were unsure what had replaced it.
- 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.
- The care plans being used were core care plans, these were pre-populated plans with space to personalise plans according to patient's needs. The majority of plans did not contain any personal details regarding the patent's care or wishes. Therefore it could not be assured that patient's individual needs had been assessed or were being met.
- The lack of personalised plans meant that it could not be established what measures were being taken to mitigate risks. For example one patient had a risk of developing pressure sores but it was not clear how this was being managed and if the measures were being effective.
- One patient told us that staff repeatedly asked the same questions and that staff did not appear to have a knowledge of their medical history. They told us they felt, "Well cared for but not always listened to". We were told they asked for a specific medication which they were prescribed but staff told them they "Weren't down for it", it was then realised that the medicine was prescribed.

Multidisciplinary Team 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.
- 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.

End of life care

- 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 saw that patients were treated with dignity, respect and compassion from staff working on the wards to staff working in the mortuary. 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.

Compassionate Care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- Patients and relatives told us, "The staff are really good", they go "Above and beyond" what we expected. They told us, "Everyone is polite" and "Our privacy is respected".
- One patient told us the ward and staff were, "Brilliant", but they needed more staff.
- There were meeting rooms on wards where more sensitive conversations could be undertaken.
- We looked at patient records and found they were completed sensitively and contained discussions that had been had with patients and relatives about their care.
- Normal visiting times were waived for relatives of patients who were at their end of life. We saw signs on doors to remind staff and other visitors about the need for privacy. 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 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.
- All staff we spoke with from nurses, bereavement officers and mortuary staff displayed an awareness of the importance of dealing with patients and relatives in a sensitive manner.

Patient Involvement in Care

- 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.
- Two patients told us that staff delivered care in a respectful manner and always introduced themselves and talked to them. They told us that they felt staff listened to them.
- Part of the end of life care planning booklet included a diary for relatives or friends to document any comments or observations in but this had not been fully introduced.
- 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 and saw that the viewing suite was divided into a waiting and viewing room. We saw the viewing area was clean and there was seating, toilet facilities, tissues and drinking water available.
- The viewing area was religiously neutral so was suitable for use by patients and relatives of all faiths.

Emotional support

- We saw records where patients and families spiritual needs had been discussed.
- One family told us how a visit from a member of the chaplaincy had brought them some peace and comfort.
- 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 not an appointment system in place to see the bereavement officer; this meant that sometimes relatives had to wait to be seen.
- 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 bereavement.

End of life care

- The chaplaincy staff told us they offered bereavement support to relatives as well as spiritual support to patients and families, although this service was under pressure 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. Religious and spiritual support was 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. There were inconsistent practices for dealing with deceased patient's property.

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 death. 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

- 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 wasn't their first language.
- There was not a clear procedure in place on how the property of deceased patients should be handled. Staff described to us various procedures. Some property was transferred to the bereavement office; other property was kept on wards for relatives to collect. This may be distressing for relatives to have to revisit wards where their loved ones died. The lack of robust procedures increased the risk of property being lost. Complaints records indicated there had been three incidents of property being lost in the past nine months. On each occasion relatives were compensated.
- 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. 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 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 patients who were under the Palliative care team were identified automatically on presentation to other health care providers/departments.

End of life care

- 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 death.
- 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

- Interpreters were available when necessary. Staff used a telephone interpreting system and also could arrange for interpreters to be available at specific times, for example, during ward rounds or meetings where care needs were being discussed.
- Multi-faith chaplaincy was available 24 hours a day seven days a week.
- Each hospital had a multi-faith prayer chapel which were open 24 hours per day.
- Christian and Muslim worship and prayers took place regularly in the hospital chapels and Prayer Rooms.
- The trust's Chaplaincy team visited wards regularly meeting patients, their families and carers, and staff to provide spiritual and religious care at times of need and uncertainty
- An 'early release scheme' was in place to release the bodies of deceased patients for burial to meet Islamic traditions.
- The trust offered free Wi-Fi to patients and staff. This enabled patients to use technology to keep in touch with family and friends
- Chargeable car parking was available at all the trust's hospitals. One relative told us that the 'pay on departure' system meant that they did not have to worry about how long they were at the hospital as there was no risk of them getting fines.
- A free shuttle bus was available between the Mid Yorkshire Hospital Trust's three hospitals.
- We found that there were inconsistent practices regarding dealing with deceased patients' property. Some property was retained at ward level for relatives to collect and some sent to the bereavement office. We asked for the policy and procedure for property of the deceased but were told there wasn't one.

Facilities for relatives

- Rooms were available on site for relatives of patients who were seriously ill or near the end of life.
- It was reported to us that the key to the relative's room was lost and families had not recently able to use this facility. We asked the trust about this and a key was swiftly found.
- Alternatively arrangements could be made for a bed to set up in the side rooms if relatives wanted to stay with their 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.
- Most 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.
- 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.

End of life care

- We saw some examples where ward resolution to concerns had been discussed and solutions found to satisfy patients and relatives. However, not all families reported a positive experience when complaining to the trust.
- One patient told us about a complaint they had made. They said the Matron had been to speak to them and their concern was being investigated.
- 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.
- The PALS office had recently relocated and the signage available did not identify where to find the PALS team.

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. Staff told us they did not feel there was recognition or response from the board about the conditions and pressures they were working under.

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.

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 good practice to ward staff.
- Staff told us that ward staff worked well together and that immediate managers were supportive to them.
- The ward staff we spoke with had few opportunities to make their voice known. They told us they had completed the staff survey but had not received any feedback on this. Staff meetings were rarely held due to staffing pressures.
- 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 these services 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.
- Ward staff spoke positively about the service they provided for patients but were under significant pressure due to staffing shortages.
- Staff were aware of the whistle blowing procedure. They told us they would report any concerns they had.
- Staff morale on the wards was poor and was impacting on the delivery and development of the end of life care. Staff told us they did not feel there was recognition or response from the board about the conditions and pressures they were working under.

End of life care

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.
- Most staff knew some of the board members but said they rarely saw them and did not know what their vision was for the hospital. Staff did not know if board members recognised or responded to the pressures that staff were working under.
- There were identified staff leads on wards for end of life care but these were not meaningful roles. There was no additional training offered and meetings were not being held due to staffing shortages.

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. The main mortuary at Pinderfields Hospital sat within the Pathology Directorate.
- 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 Pinderfields 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 Pinderfields mortuary was found to be working more effectively than the Dewsbury site although there was some inconsistency in following procedures at times. Due to the size of the teams, high sickness levels negatively impacted the running of the service.
- An action plan was developed to address issues from the audit, which included regular meetings with bereavement offices , 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 from 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 is 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 training.
- 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 some staff meetings had been held regularly in the past but low staffing levels meant these had not been held so often recently.
- 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.

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 and diagnostic imaging

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 outpatient clinics at Pinderfields, Dewsbury and Pontefract Hospitals. In 2013–2014 over 400,000 patients attended outpatient's clinics across all three hospitals, with over 216,000 of these patients attending outpatient's clinics at Pinderfields 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 28 clinical specialities providing outpatient clinics at Pinderfields Hospital. We visited clinics for urology, vascular, rheumatology, colorectal, oncology and dermatology services. We spoke with 26 staff, eight patients and three relatives.

We looked at two sets 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 and diagnostic imaging

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.

Essential equipment was not always easily available such as wheelchairs and blood pressure monitors.

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 outpatient's 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 six incidents and saw these were managed in accordance with the trust's incident management policies and the learning outcomes from each incident were documented.
- The manager told us they provided staff with verbal feedback from incidents at the daily morning informal

meeting and at more formal team meetings. Staff we spoke with confirmed the manager fed back the learning from incidents and discussed how they could do things differently to improve.

- However, when we asked to see evidence to support informal and formal discussions with staff and on any changes implemented as a result of learning discussions from incidents, the service was unable to provide this.
- 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 concerns 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 ongoing, 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

- During our inspection we saw clinical and non-clinical areas appeared to be clean and tidy, with equipment appropriately stored.
- We saw staff adhering to the trust's bare below the elbows policy. We also saw 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.
- We found cleaning audits were publicly displayed and records of cleaning were recorded in the departmental audit book.
- The outpatients department had link nurses for infection control to promote continuous service improvements and who introduced and monitored best practice guidelines.

Environment and equipment

- All of the outpatient's 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.
- We saw that there was a lack of wheelchair availability within the main atrium of the hospital, which was the main entrance people used to get to the outpatients department. We also saw recorded in staff meeting minutes for June 2014 that staff had reported shortages of blood pressure monitoring equipment and wheelchairs. It was unclear from the minutes what actions had been put in place to address the shortages in equipment.
- We found resuscitation equipment was readily available for use and daily checks of this equipment were up to date.

Outpatients and diagnostic imaging

Medicines

- Medicines were stored and managed safely, including in locked cupboards and fridges where required.
- Medicines fridge temperatures were checked daily and medication room temperatures were set at 19°C.
- One patient told us that they were, "very impressed" with the Medisure medication pack system they were provided with by the trust, which was "excellent and really works well". This system is a pre-prepared dosage system from the pharmacist which reminds and alerts patients to take their medicines as prescribed.

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 that had not be 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 two electronic patient records and saw they included comprehensive health records such as the patients' medical histories, 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 additional needs was provided through the bookings systems. This meant they were able to prepare the environment for the person and meet their additional needs.
- 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. The outpatients department also had link nurses for learning disabilities to ensure the service made continual improvements for people with learning disabilities.

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.
- Senior staff told us that urgent electrocardiograph heart monitoring could be provided in cases of emergency.
- Senior staff in the dermatology clinic, which was situated in a separate building within the grounds of the hospital, told us that if they required assistance in an emergency they called 999.
- 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 outpatient's services consisted of a dedicated team of outpatient nurses, receptionists and administration staff, which covered clinics at all three hospital sites.
- The current staffing establishment included approximately 50 (registered and unregistered) whole time equivalent nurses (WTE), and 83 administrative, clerical and call centre staff to provide and support core outpatients services across all hospital sites. Nursing skill mix was approximately 20% qualified to 80% unqualified.
- Pinderfields' outpatients department had 2.2 WTE band five registered nurses and one WTE band two healthcare assistant vacancies and recruitment to these posts was in progress.
- The recruitment of 11 WTE band two administration and clerical staff to cover the outpatient's services across the three sites was also 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 and the service did use temporary nursing staff (bank) when shortages were identified.
- Induction and competence training for staff in different roles was carried out to facilitate staff moving between departments.
- We found there were clear lines of management responsibility and accountability within the outpatient's service.
- 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.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff told us they followed NICE guidelines for the care and treatment of patients. We saw trust policies were based and developed to include nationally recognised guidance such as NICE and Royal College guidelines.

The main outpatient's 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 spoke with the senior staff responsible for managing the dermatology and urology outpatient's services. They both gave us examples of where NICE guidelines were followed, for example in dermatology the use of systemic therapies for skin conditions and in urology the use of flexible scopes, antibiotic treatments and catheterisation.
- We saw trust policies were based and developed to include nationally recognised guidance, for example NICE and Royal College guidelines.

Patient outcomes

- During the inspection the majority of patients we spoke with who were attending outpatient appointments spoke positively about their experiences.
- Most patients commented they were satisfied with the appointments system and this had worked well for them. One patient also told us they were "really impressed with rheumatology and x-ray departments".
- However, two patients commented the "appointment system can be confusing". One person told us, "It took me a while today to work the touch screen system and everyone can see my details."
- We noted from our observations of the touch screen system that patients' personal details could be observed. This issue was brought to the immediate attention of the senior manager for outpatients. who told us they would follow this up.
- We saw patients were kept informed of any delays to their appointment times and sufficient time was allocated for each patient's appointment.
- We observed staff spending time explaining to patients about procedures they were to have as part of their outpatient appointment.
- During our inspection we were approached by a relative of a patient who had been sent by the doctor to the phlebotomy clinic to have their bloods taken. Because of the time of day the phlebotomy clinic was closed. We brought this to the immediate attention of the outpatient's manager, who addressed this at the time. However, other patients in similar circumstances might have to return to the hospital on a different day for their bloods to be taken.

Competent staff

- We saw appraisals had been undertaken for between 88% and 100% of staff across the different staff groups. An appraisal is a periodic discussion between the member of staff and their manager to discuss objectives and targets to be achieved.
- We were told the reasons the service wasn't at 100% across all staff groups were redeployment and sickness, maternity leave and new starters.
- Staff told us supervision was not formalised but their manager operated an open door policy.

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 one of the vascular nurse specialists, who told us they provided a direct service to the patients and they were supported by the medical team.

Outpatients and diagnostic imaging

Seven-day services

- The main outpatient's 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 8.30am to 4.30pm for people to have their blood samples taken. We saw during our inspection the phlebotomy clinics were very busy.
- We found that the extra clinics operating evenings and weekends did not have support from the phlebotomy service. This meant patients could not have their bloods samples taken at the time of their outpatient appointment and would have to return to the hospital for this.
- We spoke with the manager of the phlebotomy service and they said many patients had complained about waiting times. A number of initiatives to reduce waiting times for patients were in progress, for example the purchasing of specific sampling equipment and development of an appointment-based system for some patients who require frequent bloods tests. 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

During our inspection patients and relatives commented positively about the care provided from all of the outpatient's 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 outpatient's staff and were happy with the care they received once they were at the clinic.
- We observed staff interacting and speaking with patients in a caring, courteous and friendly manner.
- We saw staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.
- We observed patients being moved by ambulance teams on trolleys wearing their night clothes through the main entrance of the outpatients department, which is also the main atrium entrance to the hospital. We spoke with the senior manager, who told us there was no alternative provision for patients requiring ambulance transport to leave the hospital; this may impact on patients' privacy and dignity.
- 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 and relatives we spoke with stated they felt involved in decision-making about their care and treatment.
- We saw individual outpatient consultation and examination rooms were available to promote and maintain patient confidentiality.

Outpatients and diagnostic imaging

- 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. We saw staff used these leaflets as supportive literature to explain to patients about their health problem.

Emotional support

- We saw staff were always nearby and/or in the consulting rooms to support the patients emotionally in the event of receiving difficult news and spent time talking to patients.

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.
- 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 choices 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 and to standardise access, bookings and choice operating procedures together with the staffing across all of the outpatients services. The initial backlog was reported to be around 30,000.
- 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 outpatient's services across the trust. The outpatient's 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) meting (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 outpatient's 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 signage in the main atrium of the hospital, which is also the main reception area for outpatients, was visually confusing. We found the main outpatient's reception desk and clinic locations were not well signposted. The area was noisy and confusing and we saw some of the entrance doors were not easy to use, particularly for the disabled and/or frail.
- Touch screen monitors were used by patients to check in their arrival for their outpatient appointment, but there were only two languages available for patients to access. We spoke with the senior manager, who told us they were looking at increasing the number of languages available on the touch screen monitors and this was on-going.
- Once booked in, patients waited for their appointment in the outpatient waiting area within the main entrance. We saw there were large television monitors on display and these monitors displayed patients' names and informed them which outpatient's area to attend.
- We had received comments from patients before and during the inspection that they were not comfortable with the fact that their personal details and names were displayed openly in these areas. This was brought to the attention of the outpatient manager at the time of the inspection.
- Volunteers were on hand within the main atrium, but at peak times they were they were not always available to assist people entering the hospital.
- 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 that 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 outpatient's services 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 outpatient's operational service plan.
- We spoke with one of the Patient Advice and Liaison Service team and they confirmed that the outpatient's appointment processes were a "lot better now".
- 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. This meant potentially there could be different systems in place across the trust to manage outpatient clinics.

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 outpatient's 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.
- At the time of the inspection we found the clinical divisions met weekly to monitor progress and updates on the backlog of follow-up outpatient's appointments. 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 was 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 serious incident 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 during 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.

Outpatients and diagnostic imaging

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. This meant potentially there could be different systems in place across the trust to manage outpatient clinics.
- 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 was 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 outpatient's 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 a clear line management structure, which staff understood.
- Staff were involved in providing their views about improving outpatient's 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

Outstanding practice

- The urology department had been recognised nationally for the use of green light laser surgery, which is a minimally invasive procedure for prostate symptoms. The procedure enabled patients to return home within a few hours and return to normal activities within days.
- Patients discharged from the critical care unit were invited to attend a monthly outpatient clinic run by staff from the critical care service. Patients could be referred from the clinic for psychological support if this was needed.
- The children's service had developed a 'patient group directions competency assessment' support package for the nursing team. The package ensured the nurse had read and understood patient group directions before testing their knowledge and understanding

Areas for improvement

Action the 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 hospital 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.

Outstanding practice and areas for improvement

- 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 best practice at all times.
- Ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- Ensure recommendations from serious incidents and never events are monitored to ensure changes to practice are implemented and sustained in the long term.
- Ensure there are improvements in referral to treatment times to meet national standards
- Review the skills and experience of staff working with children in the A&E departments, special care baby unit and children's outpatients' clinics to meet national and best practice recommendations.
- Ensure staff are clear about which procedures to follow in relation to assessing capacity and consent for patients who may have variable mental capacity. This would ensure staff act in the best interests of the patient in accordance with the Mental Capacity Act 2005 and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure all staff attend and complete mandatory training and role specific training, particularly for safeguarding and resuscitation. In addition ensure all staff working in urgent care settings undertake where appropriate have Level 3 safeguarding training.
- Ensure staff receive training on caring for patients living with dementia in clinical areas where patients living with dementia access services. In addition where appropriate ensure staff are trained on the End of Life care plan booklet and updated on the trust's new policy
- Ensure that issues with replacing pathology equipment are addressed to ensure that equipment is fit for purpose.
- Ensure the pharmacy department is able to deliver an adequate clinical pharmacy service to all wards.
- Ensure staff are trained and competent with medication storage, handling and administration.
- Ensure controlled drugs are administered, stored and disposed of in accordance with trust policy, national guidance and legislation.
- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure equipment in the Accident and emergency department is appropriately cleaned and labelled and then stored in an appropriate environment.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) is embedded in theatre practice.
- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours
- Ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Review the arrangements over the oversight of Gate 20 acute respiratory care unit to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013).
- Ensure the recommendations from the mortuary review are implemented and monitored to ensure compliance.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.

Outstanding practice and areas for improvement

- 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.

Action the hospital SHOULD take to improve

Action the trust SHOULD take to improve

- The trust should review the service to improve in the number of emergency admissions following an elective surgical admission.
- Ensure information leaflets for relatives and carer's of dying patients are updated following the withdrawal of the Liverpool care pathway.
- The trust should review their lone working policy and its implementation as well as their anticipatory planning for major events.
- The trust should 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. 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 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 At Pinderfields Hospital we found that there were issues over the management of soiled and contaminated linen. Some of the linen used when relatives viewed deceased patients was stained and red bags of potentially infected linen were observed left on the floor, increasing the risk of the spread of infection. Regulation 12 (2)(a),(b) and (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010: Cleanliness and infection control.

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

This section is primarily information for the provider

Compliance actions

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
Surgical procedures 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. At Pinderfields Hospital the theatre vacancy rate has increased from 6.8% to 7.8%. There are also significant staff shortages on Gate 12, Gate 20, Gate 38, Gate 41, Gate 42 and ward A2 where a high proportion of agency staff are in use to increase numbers. The recording and monitoring skill mix and competency for all agency staff has not been evidenced. The midwife establishment for the trust is currently 1:31 which is above the recommended 1:28 ratio. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	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. At Pinderfields Hospital medicines, including controlled drugs, were not always correctly stored or disposed of in accordance with trust policy, national guidance and legislation. A recent medicines management audit from the trust demonstrated that the safety of medicines had broadly not improved since 2012. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines.