The Mid Yorkshire Hospitals NHS Trust

Evidence appendix
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The Mid Yorkshire Hospitals NHS Trust was established as an NHS trust in April 2002. In 2010 the trust started providing community therapy and intermediate care services. New hospitals were also opened in Pinderfields and Pontefract. In April 2011 further expansion provided integrated care services for the Wakefield district, including adult community nursing and hospital based childrens and families health services.

In August 2015 the acute hospital reconfiguration (AHR) began, the final stage was completed in September 2017. Key changes in the reconfiguration involved the centralisation of services at Pinderfields hospital, including coronary and critical care, paediatrics, acute medicine and acute and complex elective surgery. Midwife-led maternity units were opened at Pinderfields and Dewsbury hospital, and most recently in April 2018 an urgent treatment centre was opened at Pontefract hospital.

The trust provides a range of hospital-based and community services to a population of 550,000 people across Wakefield and North Kirklees.
(Source: Trust Website)

Acute hospital sites at the trust
A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dewsbury and District Hospital</td>
<td>Halifax Road, Dewsbury, WF13 4HS</td>
</tr>
<tr>
<td>Pinderfields Hospital</td>
<td>Aberford Road, Wakefield, WF1 4DG</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>Friarwood Lane, Pontefract, WF8 1PL</td>
</tr>
</tbody>
</table>

(Source: Trust Website)
The trust has 933 inpatient and critical care beds across the three hospital sites and operates 1040 outpatient clinics and 219 community clinics per week. The trust employs around 8000 members of staff. In 2017-2018, there were 240,000 attendances in the emergency department. The outpatient department saw around 511,000 patients, 274,000 home visits were undertaken and 6,200 babies were delivered.  
(Source: Routine Provider Information Request (RPIR) P1-Beds and wards)

Services are commissioned by North Kirklees Clinical Commissioning Group (CCG) and Wakefield CCG. The trust works in partnership with the local authority and the local mental health trust.

Is this organisation well-led?

Leadership

The senior leadership team at the trust consisted of the chief executive, chairman, seven executive directors and five non-executive directors:

- Chief Executive
- Chairman
- Medical Director
- Director of Nursing and Quality
- Director of Finance
- Director of Estates, Facilities and ICT
- Chief Operating Officer
- Director of Community Services
- Director of Workforce and Organisational Development (interim since April 2018)
- Five Non-Executive Directors
- One Associate Non-Executive Director

The Director of Workforce and Organisational Development had been in an interim post since April 2018. Three of the non-executive directors were appointed in April and May 2017. The remainder of the board had been in place since our previous inspections.

The chairman of the trust was due to retire and the recruitment process for a replacement was due to start after our inspection.

Board Members

Of the executive board members at the trust, 0% were British Minority Ethnic (BME) and 62.5% were female.

Of the non-executive board members 43% were BME and 43% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>All board members</td>
<td>20%</td>
<td>53%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

The trust board of directors had a range of experience, skills and knowledge to perform its role. There had been a stable leadership team with the majority being in post since the last inspection.
The board portfolios covered all key areas within the trust and there were clearly identified and aligned to individuals.

The leadership team could describe how they monitored patient safety, quality and performance and the metrics and information used to support this. Senior leaders demonstrated an understanding of the priorities and challenges facing the trust. For example, workforce and financial performance. These challenges were key to the overall strategy for the trust and were also included in the corporate risk register and Board Assurance Framework.

The non-executive directors chaired the resource and performance committee and the quality committee. We found that some of the non-executive directors were, at times, closely involved in operational issues. This had become practice within the organisation as a result of the significant quality challenges that the trust had faced in recent years. However, this meant that there was a risk that there may not always be the level of independence needed to enable scrutiny and challenge around safety, quality and performance.

We found there was some evidence of board development activities. We were provided with information on, and the executive team spoke about, the board seminar programme. These sessions were separate to, but followed, the monthly board meetings. They provided the opportunity to increase the board’s knowledge on different topic areas. For example, safer nurse staffing, patient flow and cyber security. The board had also recently been through a process of psychometric testing.

There was no formal board development programme in place. However, there was recognition from board members that time was needed as a board to plan how they would move forward, and what support may be required from outside of the trust.

The trust undertook an annual review of the board using the NHS Improvement self-assessment framework in April 2018. There is no requirement to have external reviews, however the board had an externally facilitated well led review two years previously and had another planned for March 2019.

The chief executive had recently carried out formal appraisals of the executive directors which were linked to objectives and we saw evidence of this in the personnel files that we reviewed.

The trust workforce strategy was closely linked to the overall trust and operational development strategy. It focused on inclusive leadership and development of staff as well as supporting succession planning through talent management. In addition to this was a strategy to support talent management, this utilised the Investors in People and NHS Leadership Academy framework. At the time of inspection, the trust had just been shortlisted for a Nursing Times award for the best preceptorship programme.

From speaking with the workforce development team, we were told about extensive programmes of leadership and development starting from band three staff. This included 907 leaders who had undertaken trust leadership development. In addition, 42 individuals had also undertaken the Royal College of Nursing (RCN) Leadership Programme, and 208 band six and seven nursing and allied health professional staff had completed the RCN clinical leaders programme. The trust also provided a leadership programme for non-registered staff (bands three and four) which was accredited to a local university.

There was a leadership development forum and a ‘careers crossroads’ which helped support staff on individual development pathways by facilitating movement to other areas in the hospital.

However, we noted that the leadership and development programmes had not yet had a positive impact on the 2017 National NHS staff survey results for the trust; the question regarding support from immediate managers remained worse when compared with other trusts.

The trust had four clinical divisions; medicine, surgery, family and clinical support services and adult community services. Each division was led by a clinical director, a director of operations and
an assistant director of nursing. At speciality level the triumvirate model was replicated with a head of clinical service, patient services manager and a matron. At the time of inspection there was a system of joint accountability within each triumvirate. The executive team acknowledged that more work was needed to establish accountability and effective clinical leadership throughout the divisional structures. The trust recognised that support was needed for clinical directors to enable the clinical leadership model to become fully established and the trust was in the early stages of shifting to this clinical leadership model.

All staff spoke positively about the chief executive and many said that he had visited their wards and departments. The executive and non-executive directors undertook walkabouts across the directorates following board meetings, producing a brief report which was fed back to the board. During the core service inspection, we noted that feedback from staff was much more positive regarding the visibility of the senior leadership team than on previous inspection visits.

During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of healthcare providers are fit and proper to carry out this important role. We reviewed eight director’s files in total, of which four files related to non-executive directors and four files related to executive directors. We also reviewed the trust’s Fit and Proper Person Test Procedure (November 2016). The trust was not compliant with the Fit and Proper Persons Requirement. We found that there was a lack of consistency between the checks conducted for non-executive directors and those for executive directors. For example, no Disclosure and Barring Service (DBS) checks were conducted for non-executive directors but DBS checks were undertaken for executive directors. The trust’s Fit and Proper Person Test Procedure (November 2016) did not include any decision-making framework or policy statement on when DBS checks would be obtained for directors. We noted that non-executive directors did undertake unaccompanied ward visits so we were not clear on the risk assessment for why DBS checks had not been obtained. The four non-executive director files that we reviewed contained identification verification documents and a copy of a disqualified directors and insolvency check. There were notes on all four files that stated that details of other pre-employment checks and documentation (such as the application form, references and confirmation of qualifications) were held by another organisation. The trust’s Fit and Proper Person Test Procedure (November 2016) stated that the trust would obtain copies of proof of qualification and professional registration for non-executive directors. However, these documents were not held on any of the non-executive director files that we reviewed and there was no evidence that the trust had taken any steps to gain assurance that these documents had been obtained. There was a lack of evidence of how the trust gained assurance that directors were fit and proper on an on-going basis. For example, all of the files that we reviewed contained a fit and proper person self-declaration dated 2018, however there was only one file that contained self-declarations for previous years (as required by the Fit and Proper Person Test Procedure (November 2016). The Fit and Proper Person Test Procedure (November 2016) did not contain a process for how the trust would check that directors were fit and proper on an ongoing basis. The Chairman told us that he undertook informal on-line checks for any adverse media relating to non-executive directors but there were no records of these checks in the four non-executive director files that we reviewed.

We were concerned that there was no policy in place for if, and how often, relevant trust staff should have new DBS checks. The workforce team informed us that DBS checks were undertaken for all new staff, however these checks were not updated unless a staff member moved into a different role.
Vision and strategy

The trust’s vision was to ‘achieve excellent patient experience each and every time’. This was supported by a mission to ‘provide high quality healthcare services at home, in the community and in our hospitals and to improve the quality of people’s lives’.

The trust also had four values, they were; caring, respect, high standards and improving. During the core service inspections, we saw these clearly displayed. A clear patient focus was evident from all staff members we spoke with. The staff we spoke with were aware of the vision and values and felt they were representative of the trust and its workforce. This was reflected in the 2017 National NHS staff survey results, with a rise in the percentage of staff reporting the values of their organisation were definitely discussed as part of their appraisal. This was higher (better) when compared with the national average.

The trust five years strategy (2017-2021) outlined the following strategic objectives:

- Keep our patients safe at all times.
- Provide excellent patient experience that delivers expected outcomes.
- Be an excellent employer.
- Be a well-led and governed Trust with sound finances.
- Have effective partnerships that support better patient care.
- Provide excellent research, development and innovation opportunities.

For each objective, there were specific targets and goals and a section stating, ‘we will know what we are achieving’ to show what good performance would look like. The strategic objectives had metrics and a planned trajectory over five years. The monitoring of progress was via a strategic ‘score-card’ showing performance against the strategic objectives trajectory. This was submitted to the trust board every six months as part of a five-year strategic scorecard.

The plans for operational implementation of the strategy were not fully developed in some areas. However, we were assured that operational teams were engaged, and the clinical leadership model was integral to ensure delivery of the strategy.

The finance and performance group (FPG) oversaw the trajectory performance. Each division had their own strategy that linked in with the overall trust strategy and trust operational plan. Each division had their own monthly FPG meetings and these updated the trust FPG on a quarterly basis.

As an example, within the division of surgery division, they had a divisional objective related to the strategic objective to improve retention and recruitment of registered nurses. For this service it was specifically for the Ophthalmology service and involved role redesign and progression opportunities to develop staff and improve retention.

The development of the strategy had been done with a wide range of staff and external stakeholders and in line with the NHS Five Year Forward View and the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).

STPs are part of a national programme where the NHS, local authorities and social care form partnerships to improve health, the quality of social care and efficiency of services in a geographical ‘footprint’. The STP processes will inform part of the overall long-term strategy for the trust in terms of service configuration.

The trust contributed to the work of the STP through the West Yorkshire Association of Acute Trusts (WYAAT). This association had a Committee in Common (CiC) of all the acute trusts in West Yorkshire with an underpinning memorandum of understanding (MoU) and was the way...
through which the STP delivered its planned acute collaboration programme. The chief executive was a rotational chair at this meeting.

The trust had successfully completed a two-year acute hospital reconfiguration process with the final phase being completed in September 2017. This was focused predominantly on the centralisation of acute services at Pinderfields hospital.

There were a number of strategies and frameworks in place to support the delivery of the overall strategy. Key to this was the June 2018 quality strategy which was focused on patient safety, patient and staff experience, access to services and patient outcomes. The quality strategy was due to be implemented in autumn 2018.

The trust had developed a quality improvement system, the Mid Yorkshire Quality Improvement System (MYQIS), which was based on the Virginia Mason quality improvement methodology. Thirty-two rapid improvement workshops had taken place using the MYQIS methodology, examples included theatre pathways for patients with a fractured hip and streamlining recruitment processes.

The trust had a learning disability strategy, the director of nursing and quality was the executive lead for this. Cross system working was in place to support patients whilst in the trust. The trust was also part of Project SEARCH which worked in partnership with specialist education providers, supported employment charity and local authority children’s services. The trust offered young people with a disability an internship within the trust, to support the transition from school to employment.

The dementia and delirium strategy had recently been refreshed and was planned to go to board in September 2018. The strategy had involved members of the dementia steering group, which were multidisciplinary and included carer, mental health and executive representation. Also included were findings from the national dementia audit and NICE guidance.

Feedback from focus groups with various staff groups gave several positive examples of going ‘above and beyond’ to provide care for patients with a learning disability.

Culture

The leadership team had recognised the culture in the organisation had needed to change and staff we spoke with talked positively about the chief executive and how they had led a change in culture. We found a significant positive shift in terms of culture within the organisation, this was clearly evident from our discussions with staff and observations during the inspection, however this had not yet been reflected in the results of the 2017 NHS staff survey. We noted that staff we spoke with were much more open and engaged with the inspection team than in previous inspection visits and staff feedback was generally more positive.

During the core service inspection, staff described the chief executive and board members as much more visible, open and approachable. We found that the board members, senior management team and divisional management teams worked well together.

The vision and values of the trust were displayed throughout the hospitals and there was a focus on delivering safe care for patients. Most staff reported an improved, open and transparent culture on the wards. We found effective multidisciplinary working and teamwork across the services we inspected with staff feeling motivated and proud to work for the trust and within their teams.

Staff we spoke with described feeling well supported by their managers and were encouraged to develop their skills to enable the delivery of safe care and treatment to patients. Staff told us they felt confident in raising issues or concerns and that they would be listened to. However, this had not yet been reflected in the results of the 2017 NHS staff survey.
The trust had appointed a guardian for safe working in 2016. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. Exception reporting is the formal mechanism that junior doctors on the new national contract should use to register variations from their agreed work schedule. In line with requirements, a quarterly report was produced which was submitted to the trust board.

We reviewed the report from February 2018, which provided evidence that junior doctors were completing exception reports. We did have some feedback from junior doctor focus groups that the exception reporting wasn’t always accurate. However, it enabled ‘hot spots’ to be identified.

The data from the December 2016 to December 2017 report clearly identified this was within medical specialities. This data was used to help inform workforce planning. From reviewing the comments within the report, it was evident junior doctors felt able to escalate concerns. There was a recommendation to rapidly introduce electronic exception reporting software to further improve the process.

The trust appointed a freedom to speak up guardian in November 2016. Initially this was a part time role, however the trust board supported a business case to increase this to a full-time post in January 2018. Freedom to speak up guardians operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team.

The role was supported by an up to date policy and 12 champions who covered each hospital site and community locations. The champions were from different staff groups and there was a good mix in terms of diversity. Training was offered to these staff and there were champion forums every 8 weeks and 1:1 meetings every quarter. The freedom to speak up guardian had a ‘buddy’ at another trust and links with the regional network.

Nursing staff had attended a skills improvement session on responding to concerns. A practical guide on how to handle concerns was also provided to managers and there was a ‘speaking up’ link on the intranet homepage. The aim was to help support a change in culture so raising concerns became business as usual.

Information gathered during the core service inspections showed that staff felt culture had improved. The staff we spoke with felt able to voice concerns and knew who they could speak to. Within maternity services a programme of work had been implemented to address concerns around culture in the service and improve morale.

The guardian had a monthly meeting with the chief executive and there was a non-executive lead. A newsletter was circulated which shared themes from concerns raised and actions taken to provide assurance to staff. An example of this was in relation to ‘step down’ wards at Dewsbury hospital. Concerns had been raised by staff in response to feedback that patients weren’t getting the rehabilitation they were ‘promised’. The newsletter identified that the chief operating officer was aware of the issues and there were plans to develop an information leaflet for patients, however there were no timescales attached to this.

The guardian was increasingly confident that the freedom to speak up profile was rising within the trust. Information from the staff survey showed that up to 90% of staff stated they reported concerns. Previously the CQC received a significant number of whistle blowers from this trust, more recently this had reduced which could be an indicator that internal systems for raising concerns were being utilised more effectively by staff. In the 2017 national freedom to speak up awards the guardian for this trust was the winner in the category “Leading the change to speaking up becoming business as usual”.

Staff had access to an occupational health service, this provided counselling services, and access to help with physical health needs.

The core service inspections found that staff recognised and reported patient safety incidents. Staff felt confident in raising concerns and we saw evidence of shared learning across the trust.
The trust had a policy in place relating to the duty of candour and staff we spoke with were aware of their requirements in relation to this regulation. A review of the duty of candour requirements was undertaken by internal audit in March 2017, the trust achieved significant assurance.

The trust monitored duty of candour requirements through the quality and safety dashboard which was review at the Quality Committee. Each division presented their compliance with the duty of candour requirements. Minutes from the June 2018 committee saw 100% compliance within each division. In 2017/2018 there had been no breaches of duty of candour in the trust.

Since the last inspection, the electronic incident reporting system had been changed to include verbal and written records of duty of candour requirements. Bespoke training had been put in place for staff and information leaflets produced for patients and visitors.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>55.5</td>
<td>89.6</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Asian</td>
<td>32.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Black</td>
<td>3.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.5</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>3.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.5</td>
<td>0.2</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Diversity tab)*

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust has two key findings where performance was better than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF16. % working extra hours</td>
<td>66</td>
<td>71</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has 21 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>84</td>
<td>86</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.05</td>
<td>3.11</td>
</tr>
<tr>
<td>KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.60</td>
<td>3.67</td>
</tr>
<tr>
<td>KF17. % feeling unwell due to work related stress in last 12 months</td>
<td>41</td>
<td>38</td>
</tr>
<tr>
<td>KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.51</td>
<td>3.63</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.38</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.83</td>
<td>3.91</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>65</td>
<td>70</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.87</td>
<td>3.89</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.68</td>
<td>3.74</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.38</td>
<td>3.44</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.71</td>
<td>3.76</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.76</td>
<td>3.90</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>88</td>
<td>90</td>
</tr>
</tbody>
</table>
Key Finding | Trust Score | National Average
--- | --- | ---
KF32. Effective use of patient / service user feedback | 3.61 | 3.69
KF24. % reporting most recent experience of violence | 61 | 67
KF27. % reporting most recent experience of harassment, bullying or abuse | 41 | 47

(Source: NHS Staff Survey 2017)

Despite these results feedback from the core service inspections was that staff morale was high and there had been significant improvements since the last inspection. Staff were proud to work for the trust and the care they and their teams provided to patients and relatives.

Workforce race equality standard

There is a requirement for NHS healthcare providers to implement and report on Workforce Race Equality Standard (WRES) in the NHS standard contract. WRES is in place to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BAME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

- KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months.
- KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.
• Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The trust had an equality and diversity strategy (2016 to 2020) which included a number of equality objectives. The Trust had an Equality, Diversity and Inclusion Lead and small team. Diversity awareness was part of the trust’s mandatory training and trust wide compliance was 98%.

The chief executive had led BAME staff focus groups in January 2017. Key themes and actions were identified following these which were monitored through the resources and performance committee. The action plan had five key areas, these were; work on attitudes and behaviours, networking and support, development, mentoring and recruitment and selection. The majority of actions were shown as completed. We were told about focus groups which were held for staff on how to welcome international nurses and there was a virtual BAME network in place.

Friends and Family test

The Friends and Family Test (FFT) was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from May 2017 to April 2018.

(Source: Friends and Family Test)

The report from the patient experience sub-committee to the June 2018 Quality Committee identified that, whilst FFT responses were favourable, response rates in some areas were low. This was particularly noted in accident and emergency and maternity. The services were looking at different ways in which they could ensure information was collected, for example staff challenging each other around FFT.
**Sickness absence rates**

The trust’s sickness absence levels from March 2017 to January 2018 were higher than the England average.

(Source: NHS Digital)

**General Medical Council – National Training Scheme Survey**

In the 2018 General Medical Council Survey the trust performed better than expected for no indicators, worse than expected for five indicators (clinical supervision, induction, supportive environment, educational governance, educational supervision and feedback) and the same as expected for the remaining thirteen indicators.

(Source: General Medical Council National Training Scheme Survey)

**Governance**

There was a clear governance structure in place to facilitate quality, performance and risk information to be escalated from ward level through to the board.

The following committees reported directly to the board:

- Quality Committee
- Performance and Resource Committee
- Audit Committee
- Nomination and Remuneration Committee

Each of the committees were chaired by a non-executive director and had terms of reference. Specialities within divisions held monthly clinical governance meetings. These meetings reported to the quality committee.
As part of CQC’s ongoing monitoring and engagement with the trust, we observed the June 2018 Quality Committee. Information from each divisional group was presented with any key concerns identified. The trust board and sub-committees received monthly detailed, high quality information through the quality and safety dashboard. This contained a number of indicators separated in to the CQC domains of, safe, effective, caring and responsive. Each of the indicators then formed the performance priorities for the upcoming year with a year to date and overall target to achieve. Some of these also had a 2018/2019 target to aim towards. For example, the overall Sentinel Stroke National Audit Programme (SSNAP) level target was A-C, at the time of the report the level was a B, the aim for 2018/2019 was to sustain this level.

During the meeting we observed appropriate challenge and requests for further information or detail from the non-executive directors. We reviewed minutes from the Quality Committee and saw evidence of challenge from the non-executive team. For example, further assurance and detail was asked for with regards the backlog of surgical discharges letters waiting to be sent. There was challenge in relation to the existence of a triage process to ensure more urgent ones were dealt with as a priority. However, during the well-led inspection we noted that some non-executive directors were closely involved with some operational matters and whether this would negatively impact on the level of challenge given by some non-executive directors at board sub-committee and trust board level.

Whilst it was recognised that governance systems and processes were in place, this needed to be strengthened and embedded as we saw evidence that this did not always work in practice. An example of this was in relation to nurse staffing on the medical ward at Pontefract hospital. After raising concerns about nurse staffing levels; further concerns and requests for information were required before assurance was gained that this had been addressed.

We had some concerns over how information, particularly learning and actions were shared both across the divisions and up to the trust board. A vast amount of information was presented by different divisions and committees at the monthly quality committee meeting. Whilst this information was detailed, it was not always clear that the pertinent risks and issues were presented in a way that all staff could understand which were the key risks from the volume of information provided.

Standard reporting metrics were used which enabled a comparison between services. For example, the number of falls with harm and staff sickness levels. The trust also used this information to identify opportunities to share learning between divisions. For example, we saw in the July 2018 quality committee meeting minutes, there was a plan to have a joint quarterly meeting between the surgical and medical division to share learning from serious incidents and reviews following an infection. However, we were concerned that such mechanisms were not already in place to share learning across the trust.

There was joint working with other organisations. The trust had representation on the four local Safeguarding Boards by either the Director of Nursing and Quality or the Head of Safeguarding. These Boards had members from a range of partner organisations including primary and secondary health, child and adult social care, police, probation, education, housing and the voluntary sector.

The trust participated in MARACs (multi agency risk assessment conference) which is a victim focused information sharing and risk management meeting attended by key agencies. There was ongoing work to look at how the trust could implement a “flagging” of victims and their children discussed at local MARAC meetings. The trust Safeguarding Team was working collaboratively with the Information Governance leads to try and resolve this. The July 2018 Quality Committee meeting minutes also identified challenges with the MARAC in terms of the demand on the trust safeguarding team’s resource. There were ongoing discussions to try to resolve this.

The safeguarding team reviewed and monitored key indicators in team meetings. To enable teams and services to know how they were performing, a new safeguarding dashboard was being developed. This was planned to include links to data sources for key indicators, such as
information on Deprivation of Liberty Safeguard referrals. Currently this information was entered manually into a separate spreadsheet from the different data sources.

During our core service inspections, we observed effective and integrated working between the staff in the trust and the mental health provider. We found an improved picture in terms of understanding and of Mental Capacity from speaking with staff. Overall compliance with Mental Capacity training was 100%. However, on reviewing patient records, we found the documentation to support decisions was not always present.

**Board Assurance Framework**

The board assurance framework (BAF) was the structure used by the board to identify the principal risks to the organisation in meeting its strategic objectives. The trust had commissioned an external review of the BAF and corporate risk register and had made some changes to the documents and processes as a result of this review. The BAF identified the main risks across the organisation based on a range of information including governance reports, the risk register and performance data.

The trust provided their Board Assurance Framework, which detailed six strategic objectives and accompanying risks. A summary of these is below:

- Keep our patients safe at all times
- Provide excellent patient experience and deliver expected outcomes
- Be an excellent employer
- Be a well-led and governed Trust with sound finances
- Have effective partnerships that support better patient care
- Provide excellent Research, Development and Innovation Opportunities

(Source: Trust Board Assurance Framework - link)

The BAF linked key risks to the strategic goals. For each risk it identified; key controls, forms of assurance, examples of actual assurance, gaps in control, gaps in assurance and agreed actions for identified gaps. Each strategic objective had a risk rating score, identified executive leads and the committee through which the risks would be managed. There was some disconnect between the BAF and what was described by the leadership team.

The senior team did comment that the BAF was being reviewed and model from other trusts were being looked at. A more dynamic BAF with controls and assurances that was subject to a more in-depth review and alignment with organisational arrangements for the escalation and de-escalation of risk was required.
Management of risk, issues and performance

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£482.7m</td>
<td>£504.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£20.5m)</td>
<td>(£7.8m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£503.3m</td>
<td>£512.3m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£14.8m)</td>
<td>£4.2m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Mid Yorkshire Hospital had a planned turnover of circa £500m in 2018/19. The trust had a deficit of £19.7m in 2016/17 and £27.7m in 2017/18 and was forecasting a deficit of circa £20m in 2018/19 (£5.4m including receipt of provider sustainability funding). The trust had a recurrent underlying deficit of circa £20m.

The trust had failed to achieve its financial control total in each of the last two years. Following negotiation with NHS Improvement (NHSI) the trust had accepted its financial control for 2018/19 and the board considered this an attainable outturn position. At the time of the inspection the trust was forecasting to achieve this target, however there was circa £8m of high risk efficiency improvements which had not been fully scoped.

The trust was under NHSI Enforcement Undertakings related to the potential breach of its license to operate on the grounds of financial sustainability. By 31 October 2018 the trust is required to produce a Financial and Service Sustainability Plan to address the underlying deficit by 2020/21. At the time of the well led inspection in July 2018 the trust reported that this planning work was in progress.

The delivery of the financial plan was part of the strategic objectives. It was reflected in the BAF and the corporate risk register. The trust board identified financial performance as one the top risks to the organisation.

Finance performance was provided directly to board. The resource and performance committee were sighted on financial performance. Three non-executive directors sat on this committee. They attended and scrutinised submitted papers. The three areas which impacted financial performance were private finance initiative costs, historic negligence claims and agency staff costs.

Divisional performance monitoring was done by the finance and performance group. This group had been in place since 2016. This was chaired by the director of finance and attended by chief operating officer, director of nursing and quality and medical director. There were four finance managers in place, one for each of the divisions.

Cost improvement programmes (CIP) were overseen by the associate director of finance, who had monthly meetings with chief executive. There were a number of workstreams for CIP, for example, theatres and procurement. We were provided with information which showed the stage of development, any risk attached and dependencies. There was an executive owner for each workstream.
The board had a good understanding of the current financial position and the challenges and risks to the trust in the current year and looking ahead. However, it was clear from all the senior team that the priority was safe patient care and quality. A quality impact assessment (QIA) was completed for all improvement programmes and for projects that were likely to directly or indirectly impact on quality of services.

Trust corporate risk register

The trust provided their corporate risk register detailing their 12 highest profile risks. Each of these had a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/04/2016</td>
<td>2873</td>
<td>Cancellation of elective procedures due to lack of qualified staffing as a result of either sickness absence or unfilled agency</td>
<td>25</td>
<td>12</td>
<td>31/07/2018</td>
</tr>
<tr>
<td>14/02/2017</td>
<td>3207</td>
<td>Failure to deliver 2017/18 CIPs</td>
<td>20</td>
<td>15</td>
<td>28/02/2018</td>
</tr>
<tr>
<td>20/01/2017</td>
<td>3238</td>
<td>Yorkshire Ambulance Service (YAS) ability to carry out transfers following Acute Hospitals Reconfiguration (AHR)</td>
<td>20</td>
<td>12</td>
<td>26/01/2018</td>
</tr>
<tr>
<td>13/04/2017</td>
<td>3292</td>
<td>Risk to Ophthalmology service delivery due to a significant capacity and demand imbalance</td>
<td>20</td>
<td>6</td>
<td>26/01/2018</td>
</tr>
<tr>
<td>17/05/2014</td>
<td>1433</td>
<td>Referral to Treatment 18 Weeks Target performance</td>
<td>20</td>
<td>12</td>
<td>26/08/2016</td>
</tr>
<tr>
<td>11/07/2016</td>
<td>2997</td>
<td>Due to not achieving JAG accreditation significant risk to patient care, safety, financial sustainability and reputation</td>
<td>20</td>
<td>12</td>
<td>28/02/2018</td>
</tr>
<tr>
<td>06/02/2014</td>
<td>972</td>
<td>Failure to comply with Infection Prevention and Control Policies and Procedures</td>
<td>16</td>
<td>12</td>
<td>29/12/2017</td>
</tr>
<tr>
<td>13/10/2014</td>
<td>2170</td>
<td>Inability to successfully fill our level of registered nurse and care staff vacancies</td>
<td>16</td>
<td>9</td>
<td>08/01/2018</td>
</tr>
<tr>
<td>01/10/2014</td>
<td>2186</td>
<td>Inability to fill registered nurse and care staff shift may lead to patient harms</td>
<td>16</td>
<td>9</td>
<td>01/02/2018</td>
</tr>
<tr>
<td>Date risk opened</td>
<td>ID</td>
<td>Description</td>
<td>Risk score (current)</td>
<td>Risk level (target)</td>
<td>Last review date</td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>10/11/2014</td>
<td>2234</td>
<td>Harm to patients caused by poor falls prevention initiatives and management</td>
<td>16</td>
<td>9</td>
<td>01/02/2018</td>
</tr>
<tr>
<td>13/06/2014</td>
<td>1897</td>
<td>Harm to patients caused by poor pressure ulcer prevention and management (Community Risk)</td>
<td>16</td>
<td>9</td>
<td>29/03/2018</td>
</tr>
<tr>
<td>20/01/2016</td>
<td>2803</td>
<td>Medical Workforce - Recruitment and Retention</td>
<td>15</td>
<td>9</td>
<td>29/09/2017</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register / Board assurance framework)

Risks were calculated using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Any risks entered on to a risk register were assigned a risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. From reviewing divisional and the corporate risk registers there was evidence that the controls in place were reviewed and updated and that the mitigating actions facilitated a risk rating review. This was an improvement from the last inspection where we found risks had not been recently reviewed. Previously we had also found that not all risk registers were reflective of the risks identified during the inspection. We did not find this to be the case at this inspection.

Risks at divisional level were reviewed and discussed then discussed at the Clinical Executive group meeting. This fed into the Executive Directors meeting which went directly to the board.

We reviewed Clinical Executive group meeting minutes from March, May and July 2018. There were representatives from each of the clinical divisions, the executive team and it was chaired by the chief executive. We found that whilst risks from each division were presented there was little detail within the minutes. However, feedback from the board was that they had high level of assurance and they were able to hold divisions to account when reviewing and discussing risk and the trust confirmed that the risk references included within Clinical Executive Group and Quality Committee minutes were detailed in the papers for these meetings. However, feedback from the board was that they had high level of assurance and they were able to hold divisions to account when reviewing and discussing risk.

We saw some significant progress in relation to risks identified at the previous inspection, for example the management of deteriorating patients. However, risk management processes still required strengthening to ensure they were embedded throughout the organisation. The board were able to articulate some of key risks for the trust, these included workforce, finance and performance. However, we were not assured that the existing risk management processes were sufficiently robust to enable the trust to proactively identify risks.

An example of this was regarding medicines management. During the core service inspection, large number of stock medication past the expiry date were found in a number of locations. Once highlighted a process for checking was immediately put in place. However, this was done once the issues had been highlighted and had not been identified by risk management processes.

A number of the risks we identified at this inspection were ongoing issues that we had found at previous inspections. We discussed with the executive team about the pace of change in the organisation. We were told there had been a significance focus on the culture which had taken time to change and this was important to enable further changes to become embedded.

We were concerned that a number of ligature risks were identified during our core service inspections of the accident and emergency departments. This was raised with the trust; we were
assured that there were comprehensive risk assessment processes in place for adults and children and young people. However, the recommendations around anti ligature areas and the funds required were not due to be submitted until September 2018. We therefore could not be provided with immediate assurance about the environmental risk factors within the department.

The trust was represented on the "3 Districts" multi-agency Mental Health Partnership Group which met quarterly. There was a service level agreement for 24-hour access to mental health liaison teams both in the emergency department and on the wards. Staff told us that the response was usually within an hour when the mental health teams were contacted. The trust had signed up as a partner agency to the local mental health crisis care concordat agreement and action plan for the Wakefield area.

For children and young people, staff told us that support from the mental health trust was under resourced. We asked what support the service level agreement with the local mental health trust provided but staff were unable to tell us. Staff said this had been included on the trust risk register for the last year. The trust told us that there was ongoing work with child and adult mental health services (CAMHS) to ensure that any children or young people attending the department were cared for safely.

The Trust had been shortlisted in the 'learning disability and mental health' category of the National Patient Safety Awards 2018 for the “Winterbourne View Protocol”. The trust demonstrated work they had done in response to the recommendations from the Confidential Inquiry into Premature Deaths of People with Learning disabilities. For example, the Trust reviewed attendances and patterns of emergency department visits to capture multiple attenders from the same residential or supported living addresses. The VIP team looked at reasons for attendance to identify any potential safeguarding alerts or ineffectual care plans which could lead to poorly managed health conditions.

The corporate risk register showed that staffing was a key risk and remained a challenge. Nurse staffing vacancy rates were 13% (approximately 230 whole time equivalent staff) across the trust. Significant work had been done with regards recruitment and retention of staff. Ninety newly qualified staff were due to begin working at the trust in September 2018. At the time of inspection, out of 200 trusts, the trust was one of seven shortlisted for the Nursing Times award for best recruitment and employer of the year.

The trust had developed a comprehensive programme to support, recruit and retain their nursing workforce. To further support the recruitment of nurses the trust had developed a School of Nursing at Dewsbury which was currently the only one in West Yorkshire. This was a key component to the trusts strategy regarding nursing. Another component to retain newly qualified nurses was the graduate nurse programme, this started six months before student nurses were due to qualify. They were put in to a cohort and provided with support via workshops on areas such as resilience and transition. This was in response to the previous year where 18 nurses left the trust within six months of qualifying; this had improved in 2018 only two had left. The trust had also increased the number of student nurse’s places with a local university to the extent they couldn't fill them all.

There was also a focus on nurses due to retire to see what could be offered if they wished to return to work.

There was a similar focus with the medial workforce in terms of retention. A key area was looking at support for junior doctors. One approach was providing them a senior nurse as a 'buddy' and ensuring a five-minute phone call with their consultant each day for the first four weeks to discuss any concerns .

The trust was trying to shift the focus from junior doctors being a resource to them being there to learn. It was hoped this would encourage them to remain at the trust.
Another key area was looking at additional roles, such as advanced nurse practitioners, and how they could support gaps in medical rotas. Band five pharmacy technicians were to be trialled to help administer medications to patients on the wards. This was following a care contact time review which showed on the care of the elderly wards 40% of nurse’s time was spent on medicines management.

A bi monthly staffing report went to the trust board which triangulated fill rates with levels of harm. We were told from September this would change to include required and actual staffing numbers. Staffing reviews took place every six months, this last occurred in January 2018. However we were concerned that this had not highlighted any of the nurse staffing concerns we found within medical services at Pontefract hospital.

A clear process for staffing escalation was described and we observed this during our core service inspections. The safer nursing care tool was used to support risk based decisions when staff were moved to support other areas. There were band seven nurses at Pinderfields and Dewsbury each day to manage staffing as well as two matrons for nurse staffing.

Further work was needed to be able to provide the same information for allied health professionals.

**Information management**

The board received a vast amount of detailed information. As previously discussed some of the board development sessions were focused around increasing understanding on the figures and information they were presented with.

It was acknowledged by the board that their focus should be on delivery and outcomes. To help support this there had been a move towards exception reporting at sub-committees and board, which the board reflected had helped provide focus.

The board and its sub-committees received information in order to gain assurance on implementing the trust’s strategic objectives and operational and financial performance. Board and committee papers provided information through a combination of progress reports, meeting minutes and integrated performance dashboards.

The trust had developed a quality and safety dashboard to enable appropriate oversight and challenge. Key indicators were linked to the CQC domains. There was a RAG (red, amber, green) rating system for key indicators and a performance chart showing trends over the previous six months. Many of the indicators were benchmarked either nationally or locally to help monitor and improve performance and outcomes.

Data quality performance was also monitored by NHS Digital’s Data Validity Summary. This gives an average of data quality performance across all fields in the Data Quality Dashboards. The summary for the trust from 2017 to February 2018, showed an overall data quality accuracy score of 96.9%. This was slightly higher than the national average score of 96.5%, and was an improvement from March 2014 when it was 94.1%.

The trust had a well-established Data Quality team. The two main areas of focus for the team were referral to treatment data quality, and Patient Master Index and inpatient data quality. Key to their role was ensuring electronic data was recorded accurately and in a timely manner to support the trust’s clinical and business requirements. There were systems in place to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards.

The Data Quality teams had produced a data quality policy, this was reviewed and updated on an annual basis. Overall compliance with the policy was monitored by the Data Quality Group and the Internal Quality and Assurance Group. Specific elements of data quality were also discussed.
routinely in the Mortality Steering Group, Planned Care Group and the Corporate Information Governance Steering Group.

Data Quality audits were undertaken monthly on the Trusts Referral to Treatment (RTT) waiting times. This sample based audit was undertaken to provide assurance that the Trust’s RTT waiting list was accurate. The audits began internally in April 2016, at this time RTT data quality reported a 24.5% sample error rate. The audit in March 2017 showed a 44% improvement in error rate. Work was ongoing to improve this further and progress is monitored through the Internal Planned Care Group.

The RTT Data Quality team was audited annually as part of the trust’s internal audit program. The overall aim of this was to provide assurance on the validity, accuracy and reliability on data reported externally and in the Trust Performance report. A recent review in March 2018 reported a finding of significant assurance. This reflected what was found during our core service inspection of outpatients.

The trust had completed the information governance (IG) toolkit in March 2018. The toolkit required organisations to undertake monthly audits comparing a number of data fields within the electronic record, with information held in the physical case notes. The audit reported accuracy of case notes as 92.06% for waiting list records, 94.02% for inpatient records and 92.64% for outpatient records.

The trust supported these arrangements and policies with training so staff knew how to manage information correctly. Overall compliance with information governance training was 84%.

The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system or the NHS strategic executive information system. Staff across the trust could access information through meetings, updates, newsletters and through the trust’s intranet site. Policies and procedures were available on the trust intranet.

**Engagement**

The national NHS staff survey (2017) findings showed the trust scored 3.62 for staff engagement. This was an improvement from the previous year, however remained below (worse than) the national average when compared with trusts of a similar type (3.78).

There has been a focus on staff engagement. Most staff reported that the leadership team were visible and approachable. The executive and non-executive directors undertook a scheduled programme of walkabouts across the different services.

Feedback from CQC focus groups and interviews with staff during the inspection showed mixed responses from all staff groups. Some staff spoke positively about the level of engagement and support they received, whilst others felt there was still further work to be done.

Historically there had been a lack of medical engagement at the trust. The trust hoped that the clinical leadership focus in the triumvirate model would be one way to improve this

Staff engagement took place through a variety of methods, including workshops, staff surveys, listening events such as ‘little conversations, big actions’, bulletins and newsletters. The work in relation to staff recruitment and retention was a significant part of staff engagement. One such example was the trust supporting staff to work in other wards or departments and making this a simple process.

There were a number of initiatives in place to recognise and celebrate staff achievements. This included ‘MY star awards’, a recognition scheme for teams or individuals. The trust also had an annual ‘celebrating excellence’ event and awards night dinner. We were provided with examples
of simple things which had a big impact, such as staff being provided with ice lollies during the hot weather.

The employee benefits team had recently held health and wellbeing roadshows across all 3 hospital sites which over 1,900 staff attended. Information was provided on a number of benefits for staff such as, occupational health and wellbeing and car lease schemes.

The Director of Nursing and Quality was responsible for the oversight and management of patient experience, voluntary services, complaints and the patient advice and liaison service (PALS). Patient stories from NHS choices were presented at board meetings. There was a stakeholder forum made up of patients who have used services at the trust, they fed in to the patient experience group and sat on the recruitment panel for senior staff.

There was engagement with the public over the reconfiguration of services at the trust. In response to public feedback it was agreed that the emergency department at Pontefract Hospital would become an urgent treatment centre and remain open 24/7.

The trust participated in national patient surveys, for example the friends and family test and CQC inpatient surveys. There were dementia specialist nurses and a learning disability specialist nurse in post. We saw positive examples of how the trust had engaged with certain groups for the benefit the local community. For example, working with the local job centre to provide employment for 18 people.

The trust routinely engaged and collaborated with other healthcare providers. The trust was a member of the West Yorkshire and Harrogate STP and worked with other trusts within the WYAAT, the Working Together Partnership (WTP) and South Yorkshire Integrated Care System.

The trust engaged with local commissioners, NHS improvement and local GP service representatives. The trust had also worked with Healthwatch to get feedback from the public. Feedback from stakeholders we spoke with demonstrated positive engagement with the trust.

Learning, continuous improvement and innovation

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>90%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60</td>
<td>100%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3,308 (complaints)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)
Number of complaints made to the trust

The trust received 1125 complaints from April 2017 to March 2018 for acute services. The outpatients core service received the most complaints with 26% of all acute complaints.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>298</td>
<td>26%</td>
</tr>
<tr>
<td>Medical care</td>
<td>281</td>
<td>25%</td>
</tr>
<tr>
<td>Surgery</td>
<td>179</td>
<td>16%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>176</td>
<td>16%</td>
</tr>
<tr>
<td>Maternity</td>
<td>88</td>
<td>8%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>42</td>
<td>4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>33</td>
<td>3%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>26</td>
<td>2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>2</td>
<td>0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The Quality and Safety dashboard from June 2018 showed that all divisions were RAG rated green, indicating complaints had been handled within the agreed trusts timescales.

Complaints were reviewed at divisional governance meetings then reported at the monthly Quality Committee meeting. The divisional reports included information on the number of complaints, timeliness of responses and any themes. For example, in the June 2018 Quality Committee meeting minutes it was identified there had been a drop in the year to date number of complaints within the division of surgery compared to the previous year; 54 compared to 83 the previous year.

It was identified staff attitude was becoming a theme when reviewing the complaints. This was being further reviewed to understand if this related to specific staff groups or specialities.

The same minutes noted that overall there had been a reduction of 22% in the number of formal complaints received in the last financial year. This was positive. It was also noted that there was a corresponding increase in PALS. This was also positive as it meant a larger number of queries were being addressed in real time.
Compliments

From April 2017 to March 2018, the trust received a total of 685 compliments for acute core services. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>128</td>
<td>19%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>115</td>
<td>17%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>110</td>
<td>16%</td>
</tr>
<tr>
<td>Critical care</td>
<td>92</td>
<td>13%</td>
</tr>
<tr>
<td>End of life care</td>
<td>83</td>
<td>12%</td>
</tr>
<tr>
<td>Surgery</td>
<td>72</td>
<td>11%</td>
</tr>
<tr>
<td>Medical care</td>
<td>59</td>
<td>9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>9</td>
<td>1%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>5</td>
<td>1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which accreditation programmes the trust’s acute services participate in:

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medical care</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>End of life care</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Surgery</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>Diagnostics</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Serious Incident Process Overview

There were clear processes in place for the reporting, investigation and learning from incidents. Serious incidents, complaints and patient deaths were reviewed at weekly and monthly divisional meetings. Serious incidents were also reviewed at the Patient Safety and Clinical Effectiveness committee. They submitted a report to the Quality Committee.

The June 2018 Quality Committee meeting minutes recommended the monitoring and reporting control of serious incidents needed to be more robust. This was in response to a serious incidents actions backlog from 2016
Urgent and emergency care

Facts and data about this service

Urgent and emergency care services are provided at all three hospital sites:

- Pinderfields Hospital emergency department (ED)
- Dewsbury and District Hospital ED
- Pontefract Hospital urgent treatment centre (UTC)

Following a reconfiguration of acute hospital services at the trust, which was completed in September 2017, emergency and complex care is now centralised at Pinderfields Hospital. The ED is open 24 hours a day, seven days a week, and is a designated trauma unit. It has a separate children’s ED which is part of the division of medicine; nursing staff are managed by the division of children’s services. The children’s ED operates 24 hours a day, seven days a week.

Activity and patient throughput

**Total number of urgent and emergency care attendances at The Mid Yorkshire Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017**
From April 2016 to March 2017 there were 236,645 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2016/17 compared to 2015/16. In both years, the proportions were higher than the England averages.

(Source: NHS England)
Urgent and emergency care attendances by disposal method, January to December 2017

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Case Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>54,129</td>
</tr>
<tr>
<td>Discharged*</td>
<td>32,209</td>
</tr>
<tr>
<td>Referred*</td>
<td>17,622</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>194</td>
</tr>
<tr>
<td>Died in department</td>
<td>9,376</td>
</tr>
<tr>
<td>Left department#</td>
<td>2,475</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>129,256</strong></td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

From January to June 2018, there were 58,494 patient attendances Pinderfields Hospital ED. This resulted in 18166 patient admissions.

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training and 95% for role-specific mandatory training.

Trust level

At our last inspection in 2017 we found that mandatory training levels were not meeting the trust standards. This was also a concern following our inspection in 2015. At this inspection the staff we spoke to told us they had completed their mandatory training, or had plans in place to do so. The data we reviewed showed in urgent and emergency care across the three sites, the trust target of 95% was met for four of the nine mandatory training modules. The remaining five were below trust standard, and ranged from fire safety at 77% to safeguarding children at 94%. The overall trust compliance rate for mandatory training was 90%.

The trust target of 85% was met for three of the 16 role specific mandatory training modules. Nine modules had a compliance rate of 75-85%. The remaining four modules were below 75%, these were: safeguarding children level 2 at 68%, safeguarding children level 3 at 73%, annual resuscitation training at 69% and Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) training at 52%. The trust was unable to provide site or role-specific data. The overall trust compliance rate for role-specific mandatory training was 78%.

We spoke to the clinical educator for the department who had been in post for seven months, and was keen to improve access to training and training standards. An education strategy was in place and staff training compliance was closely monitored. Staff could access training online from work and home computers, and alerts were generated automatically to inform them when training was due. The clinical educator followed up these alerts to encourage staff to remain compliant, but said that some staff were reluctant to complete training or did not have time. Staff told us they felt...
training generally had improved, but time available to access training was limited and sometimes they had to wait for places on face-to-face training courses to become available. Band 5 nursing staff received immediate life support (ILS) training, but were not funded to access advanced life support (ALS) or trauma nursing core course (TNCC). The department had developed ‘in-house’ trauma and resuscitation training courses to mitigate this.

Safeguarding

Safeguarding training for adults and children (level 1) was part of the trust’s mandatory training programme and eligible staff must complete it every three years. The trust set a target of 95% for completion of safeguarding training. There were 276 urgent and emergency care staff eligible for safeguarding adults level 1 training, with a compliance rate of 92%. There were 276 urgent and emergency care staff eligible for safeguarding children level 1 training, with a compliance rate of 94%. The information provided to us was at trust level and was not broken down into staff groups or hospital site.

Safeguarding training for adults (level 2) and children (levels 2 and 3) was part of the trust’s role specific mandatory training and eligible staff must complete it every three years. The trust set a target of 85% for completion of role specific safeguarding training. There were 231 urgent and emergency care staff eligible for safeguarding adults level 2 training, with a compliance rate of 74%. There were 74 urgent and emergency care staff eligible for safeguarding children level 2 training, with a compliance rate of 68%. There were 157 urgent and emergency care staff eligible for safeguarding children level 3 training, with a compliance rate of 73%

At this inspection the service had systems in place to identify and manage children and adults at risk of abuse, including domestic violence. The safeguarding policy was available to staff on the intranet. Staff we spoke to, in both the adult and children’s EDs, told us they had completed safeguarding training as part of their mandatory training, which included specific training about child sex exploitation (CSE), female genital mutilation (FGM) and domestic violence.

Nursing and medical staff told us they knew how to recognise a potential safeguarding concern, and knew how to raise concerns. They could describe the process, give examples from their own practice and demonstrate how to access trust guidelines.

Safeguarding alerts were flagged on children’s records; these would be picked up by reception staff and the appropriate nursing staff would be alerted. Children’s records were reviewed daily by paediatric liaison nurses, to check that information had been completed correctly and shared appropriately, for example with general practitioners (GPs), health visitors and school nurses, and to ensure no incidents had been overlooked.

Assessment documentation for both adults and children contained sections for safeguarding information to be completed by staff. We reviewed 23 paediatric records and found that safeguarding information had been completed on 20, but most patients did not present with any safeguarding risk factors or concerns.

Each paediatric patient record showed the number of times a child had accessed ED services in the last 12 months; we checked 23 records and found that in three cases the number of previous attendances had been recorded inaccurately. The remaining 20 sets of notes had all been completed correctly.

At our last inspection we said the trust should ensure that families discussed at a Multi-Agency Risk Assessment Conference (MARAC) should be flagged on the electronic system. At this inspection we found that flagging still did not routinely occur. Following inspection, the trust has informed us that a system of ‘consensual’ flagging was planned to commence; those involved in a MARAC who gave consent would be flagged on electronic records. Staff told us that they identified
very few incidents of domestic violence, however they were aware of the referral process and could provide patients with a helpline number. This number was also available on tear-off strips located in toilets, and printed on lip balms which patients could be discreetly offered.

**Cleanliness, infection control and hygiene**

During inspection we found all areas of the department, children’s area, waiting rooms and toilets to be visibly clean and tidy, and saw cleaning in progress at several times during our visit. In the paediatric ED, toys met infection control standards and had been cleaned regularly. We spoke to domestic staff who described their cleaning schedule, and we saw evidence of completed cleaning checklists in the adults’ and children’s departments. The domestic staff told us that checklists were routinely reviewed by a domestic supervisor. We observed different coloured mops and cloths used for different areas.

The trust had an infection, prevention and control policy, which provided guidance for staff about cleaning, decontamination and personal protective clothing. Infection control training was part of the trust’s mandatory training programme, and staff must complete it every two years. In urgent and emergency care across the trust’s three sites, there was a target of 95% compliance; the actual compliance rate was 87%.

Disposable curtains were not being used in the department. Domestic staff told us they had previously been in use but had been recently changed to fabric curtains. We were told these should be changed on a six-monthly basis, or when soiled, but the domestic staff we spoke with told us they knew of no record of this, though they said the curtains were changed frequently and they appeared visible clean. Following inspection, the trust has provided us with a record, held by the facilities department, showing scheduled dates for curtain changes. The records did not provide clear assurance that the changes had taken place. ‘I am clean’ stickers were used routinely around the department on reusable equipment, and all those we checked had been dated and signed correctly. All equipment appeared clean and we observed staff disinfecting equipment between patients. Sharps bins were stored at an appropriate height and had not been overfilled. They were signed and dated correctly and apertures were temporarily closed when not in use, in line with national guidance.

We checked ten mattresses in the department and all were clean and intact. We viewed monthly mattress audits completed by the ward manager and were assured that all mattresses were thoroughly checked and those unfit for purpose were documented and removed.

Personal protective equipment (PPE), including aprons and gloves, was readily available in all areas of the department. There was good access to handwashing facilities and hand sanitising gel. We observed staff using correct hand decontaminating procedures, and they were compliant with the trust’s ‘bare below the elbows’ and uniform policies.

Hazardous substances were stored in a locked cupboard, and all other cleaning supplies were stored in a cupboard with a keypad lock. We checked the dirty utility and found it to be clean and tidy, with waste and laundry separated appropriately. The door to the room had a keypad which had been left disengaged, but no harmful substances or chemicals were stored here. We highlighted this to staff on duty who told us the room would normally be secured. We rechecked the next day and the keypad lock was engaged. Regular flushing, for example of showers, to prevent infections such as legionella, was carried out daily and signed off by the estates department.

The department had cubicles available for patients who required isolation for the prevention and management of actual or potential infection, and there was a separate decontamination room.

**Environment and equipment**
The waiting area used by patients had sufficient seating available, which was secured to the floor, however the seats faced away from the reception desk so patients were not directly visible to reception staff. There was a dedicated entrance for ambulance patients, however this was not secure and we observed it being used on numerous occasions by people to access different parts of the hospital. There were assessment rooms at both sides of the main waiting room which were used by emergency nurse practitioners (ENPs), advanced nurse practitioners (ANPs) and GPs for triage and treatment, which were equipped with safety alarms.

The mental health assessment room was located on a busy corridor in the majors area. It was ligature free and staff could see into the room through an observation window if they needed to monitor a patient who posed a risk to themselves or others.

The resuscitation room had six treatment bays plus a designated paediatric bay, which was checked and maintained by staff from the paediatric ED. The adult bays were in a line down one side of the room, making it difficult to directly visualise all patients. We found resuscitation equipment to be compliant with safety checks and there was evidence of daily checklist completion. Resuscitation trolleys were stocked appropriately and all equipment checked was in date. We checked electrical equipment, including patient monitors, and all portable appliance testing (PAT) labels were up to date.

There was a separate children’s emergency department (ED) with a secure entry system, where paediatric patients went directly after registering. The children’s ED consisted of a waiting room, triage room and eight cubicles. Cubicle 8 had a door, rather than a curtain, and a separate toilet, so it could be used as a private room when necessary, or to isolate patients when required. We were told that children and young people with mental health issues were sometimes assessed in this cubicle, following a risk assessment, but that portable equipment would be removed and patients would need to be accompanied.

We checked items of electrical equipment in the children’s area and found some portable appliance testing dates were overdue; this was highlighted to the nurse in charge. We were informed that the medical physics department was responsible for testing on a rolling programme, which was closely monitored, and there was a 60-day period after the recorded due date in which the items could still be tested. They were aware of testing dates and all items were still safe to be used.

We found that all consulting and treatment cubicles were an appropriate size and contained the necessary equipment, however staff told us that the majors area in the adults’ ED was difficult to manage due to the layout of the department. This was particularly noticeable in several new cubicles at the end of the majors' area as these could not be viewed easily from other parts of the department and we did not see them being used during our inspection.

We checked the major incident equipment storeroom and found some of the equipment was out of date. We escalated this to the nurse in charge and were told that some of the out of date equipment was used for training purposes only and had since been clearly labelled. Following the inspection, we received assurance from the trust that other out of date equipment had been dealt with accordingly, and it had been highlighted to staff that expiry dates must be checked.

Assessing and responding to patient risk
Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from April 2017 to March 2018.

In March 2018 the median time to initial assessment was 17 minutes compared to the
England average of 9 minutes.

During this inspection we tracked the time of arrival to time of initial assessment for 18 patients who arrived by ambulance and found that 15 had been assessed within 15 minutes. The median time to initial assessment was 13 minutes. We spoke to ambulance staff who told us they felt waiting times in the department had improved. We also spoke to five patients who arrived by ambulance, and all said they had been seen straight away. Staff told us they felt that the introduction of a designated ‘flow nurse’ to the department had made a big difference in reducing ambulance handover times.

In addition to this we looked at triage times on 20 sets of adult notes (both from patients who arrived by ambulance and those who self-presented to the department) and found that 15 had been assessed within 15 minutes. The median time from arrival to initial assessment was 12.5 minutes. We reviewed 23 sets of paediatric notes and found that 16 had been assessed within 15 minutes. The median time to initial assessment was 12 minutes.

Ambulance – Time to initial assessment from April 2017 to March 2018 at The Mid Yorkshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for Pinderfields Hospital

From May 2017 to April 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Pinderfields Hospital.

In April 2018, 50% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - Pinderfields Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Pinderfields Hospital
Following the inspection, the trust provided ambulance handover data for all three hospital sites for the period May 2017 to July 2018. This data shows that over this period the percentage of ambulance handovers over 30 minutes ranged from a maximum of 4.3% in December 2017 to a minimum of 0% in May and July 2018. From February 2018 there was a substantial reduction in the percentage of handovers over 30 minutes at Pinderfields Hospital.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From March 2017 to February 2018 the trust reported 139 “black breaches”, with an upward trend over the period.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of black breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>2</td>
</tr>
<tr>
<td>April 2017</td>
<td>5</td>
</tr>
<tr>
<td>May 2017</td>
<td>3</td>
</tr>
<tr>
<td>June 2017</td>
<td>5</td>
</tr>
<tr>
<td>July 2017</td>
<td>8</td>
</tr>
<tr>
<td>August 2017</td>
<td>10</td>
</tr>
<tr>
<td>September 2017</td>
<td>22</td>
</tr>
<tr>
<td>October 2017</td>
<td>17</td>
</tr>
<tr>
<td>November 2017</td>
<td>3</td>
</tr>
<tr>
<td>December 2017</td>
<td>39</td>
</tr>
<tr>
<td>January 2018</td>
<td>25</td>
</tr>
<tr>
<td>February 2018</td>
<td>0</td>
</tr>
</tbody>
</table>

Since the completion of the acute hospital reconfiguration (AHR) in September 2017 Pinderfields Hospital has become the main receiving ED for patients who are acutely unwell or have complex needs. Many of the staff we spoke to told us the department had become much busier, with more patients arriving by ambulance who would previously have been admitted to Dewsbury Hospital, and that the pressures over winter had been much greater than in previous years.

At our last inspection we found that recording of national early warning scores (NEWS) was not consistent. The trust used NEWS to identify a patient’s condition based on their recorded clinical observations; the NEWS score indicates whether a patient is stable, improving or deteriorating and...
therefore requires escalation to a higher level of care. At this inspection we reviewed 20 sets of adult notes and found that 16 had clinical observations/NEWS recorded; three of those without NEWS recorded had presented with minor injuries. We reviewed 23 sets of paediatric notes and found that 14 had clinical observations recorded. We found that patients had been escalated appropriately when necessary.

We were concerned at our last inspection that the triage training process was not robust and varied across the trust, with relatively inexperienced nurses carrying out triage. At this inspection we found that all registered nurses were trained in triage assessment and used a recognised triage tool. Nursing staff who had been in post for six months or more, and who had completed the triage training, could carry out triage once their competency had been assessed.

An initial streaming process took place when patients registered at reception; on inspection we were concerned that this was done by reception staff who were not clinically trained. This is not in line with national guidance. Patients were streamed using a flowchart into ‘red chairs’ for majors and ‘blue chairs’ for minors, depending on their initial clinical presentation. The seats in the waiting area were positioned to face away from the reception, so if a patient became unwell it may not be immediately noticed.

The main department had a designated mental health assessment room. This was located on a busy corridor in the majors area. It did not have separate toilet facilities or adjustable lighting.

Staff in the department had access to appropriate triage and risk assessment tools to support them to identify and assess patients with suspected mental health conditions. This included an assessment of any immediate risk patients may pose to themselves or others, due to their presenting mental health problems. The risk assessment tool was traffic light rated – red, amber, green - with clear recommended action staff should take depending on the assessment of a patient’s initial mental health assessment and associated risk. Patients who presented with higher risks of harm to themselves or others were observed by emergency department staff or security staff. Patients waiting for an inpatient mental health bed could remain in the emergency department for up to 24 hours, often observed by security staff. The psychiatric liaison team was available 24 hours a day, seven days a week. The team aimed to respond quickly to referrals made by the emergency department, usually within one hour.

All cubicles were equipped with patient call bells, and each patient we spoke with had access to the call bell. We viewed monthly audits completed by the department matron and it was documented that 100% of patients reviewed had a call bell available.

Patients told us they felt safe in the department. We saw that patients at risk of falls had been assessed and were given a green wristband to help identify them to staff as needing more support with mobility.

We saw that the initial assessment rooms adjacent to the waiting room had security alarms, enabling staff to summon help if needed. Staff told us that there were very few incidents in which they felt unsafe and told us they were confident that they would be able to defuse potentially threatening situations using de-escalation techniques.

A patient safety checklist had been developed, for staff to complete at regular intervals, giving details of patient care actions and assessment to be undertaken. We reviewed the checklist audit carried out in June 2018 and, of the ten patients’ notes that were reviewed, 100% had checklists in place. During our inspection we reviewed the notes of three patients who had prolonged stays in the ED (over four hours) and two out of three did not have safety checklists completed.

We spoke with the sepsis lead consultant who told us that there had been significant improvements in sepsis care within the trust. Sepsis assessments were completed to flag patients at risk, and a pathway was followed to provide a specified bundle of care, which included timely
administration of antibiotics. The trust had appointed a designated sepsis nurse. There was a children’s sepsis pathway also due to be produced. We saw two examples of sepsis care and escalation of a deteriorating patient during our inspection and staff we spoke to told us they felt their own awareness of sepsis treatment and pathways had improved.

There was a specialist stroke nurse on site who took referrals from the ED to assess and provide care for stroke patients. We spoke to a member of ambulance staff who told us they had recently made a direct referral to the stroke nurse; the patient was assessed on arrival and admitted directly to the stroke ward. We were told by staff that the cardiac specialist nurses were also very responsive and often came to review patients in the department.

Emergency Department Survey 2016

The trust scored “about the same as other trusts” for all five of the Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

Nurse staffing

The trust reported the following qualified nursing staff numbers from April 2017 to March 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse staffing</td>
<td>137</td>
<td>155</td>
<td>89%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From April 2017 to March 2018, the trust reported a vacancy rate of 12.8% for nursing staff in urgent and emergency care. This is worse than the trust target of 9%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At our last inspection, we found that the department had nurse staffing shortages and we said the trust must ensure there were suitably skilled staff available, taking into account best practice, national guidelines and patients’ dependency levels. Both qualified and unqualified nursing staff were frequently being moved to wards to cover absences, thus leaving the ED short-staffed. Bank and agency nurses were used to cover gaps in the rota.

At this inspection we were told that there were 17 whole time equivalent band 5 nurse vacancies in the ED. There were six new starters due to join the department in September 2018. Many staff, both doctors and nurses, told us that nurse staffing levels often felt inadequate and unsafe, particularly in relation to the layout of the majors’ area and the resuscitation room. Nurses were still occasionally asked to cover vacancies in other areas.

The department had previously run the Baseline Emergency Staffing Tool (BEST), which is a national tool developed to calculate staffing numbers and skill mix needed, taking into account workload and rostered staffing levels. We were told that previously the tool had calculated four extra qualified nursing staff were required. The department was in the process of running the tool again during our inspection, but there had been a problem with the software so the results were not available. We witnessed two qualified nurses report sick for the same shift; this resulted in a nurse being moved from Dewsbury Hospital and a request being sent out for agency cover.

During the day the nursing and healthcare staff were allocated to work in specific areas for the duration of their shift. The majors’ area was split by cubicle numbers into two teams to provide consistency for patients. There was a band 7 nurse as shift lead who would oversee the department, review patient status and report issues within ED as necessary. Designated nursing staff also worked in the ambulance assessment area, the triage area and the resuscitation room.

We reviewed four weeks of nursing rotas to compare the planned and actual registered nurse figures. Day shifts were covered with the planned number of 13 registered nurses, except for three shifts with 11 nurses and six shifts with 12 nurses. There was a twilight shift in the department, with a planned number of three registered nurses per shift. On two occasions there had only been two nurses on shift. At night, there were 10 planned registered nurses in the department; four of the shifts we looked at had nine nurses and the rest were fully staffed.

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 10.6% for nursing staff in urgent and emergency care. This is better than the trust target of 12%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 5.2% for nursing staff in urgent and emergency care. This is similar to the trust target of 4.8%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
We spoke to the matron for the department who told us the department relied on agency nurses to fill gaps in the rota, usually with one to two agency nurses per shift. Data supplied to us by the trust showed that, in the three-month period from April to June 2018, a total of 5856.73 qualified nursing hours were worked by bank and agency staff.

**Medical staffing**

The trust reported the following medical staffing numbers from April 2017 to March 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staffing</td>
<td>78</td>
<td>74</td>
<td>105%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

At our last inspection we found that medical staffing in the department was not always meeting planned staffing levels. There was a reliance on locum doctors to fill gaps in the medical rota and there were concerns about the long-term sustainability of consultant cover.

At this inspection we were told that the number of doctors in the department had been increased due to the change of services at Pontefract urgent treatment centre; two specialist registrars had transferred to work at Pinderfields. All medical staff worked across sites at both Pinderfields and Dewsbury ED.

Consultant cover in the department was from 8am until 11pm on weekdays. Out of these hours, consultants were on call. This was less than the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. The consultant cover in the department on a weekend was from 8am until 5pm. Staff told us that consultants were readily accessible on call, always willing to help and attend the department when needed, with many regularly staying after the end of their shift.

We looked at four weeks of consultant rotas and all clinical shifts appeared to be covered. Out of the 28 days we reviewed, 18 had at least one locum consultant working. Consultants also had designated non-clinical time allocated to them on the rota.

We looked at four weeks of specialist registrar rotas and of the 28 days reviewed (all shifts) five were uncovered; four of these due to sickness.

We looked at four weeks of junior doctor rotas and of the 28 days reviewed (all shifts) seven were uncovered; four of these days had two vacant shifts and two days were due to sickness.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 4.7% for medical staff in urgent and emergency care. This is better than the trust target of 9%.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 4.9% for medical staff in urgent and emergency care. This is better than the trust target of 12%.
Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 0.4% for medical staff in urgent and emergency care. This is better than the trust target of 4.8%.

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

Staffing skill mix

During January 2018, the proportion of consultant staff reported to be working at the trust were about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 61-whole time equivalent staff working in urgent and emergency care at The Mid Yorkshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>23%</td>
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</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Records

At our last inspection we found that record keeping in relation to NEWS, pain scores and comfort rounds needed to improve and we found gaps in information in the records we looked at.

At this inspection we reviewed 20 sets of adult notes and found that NEWS was recorded in 16 out of 20 and pain scores were recorded in 14 out of 20.

A patient safety checklist had been developed and introduced into the department, which included assessment of patient comfort, pressure area care and whether food or drink was required. We found that completion of the checklist was inconsistent; documentation had been completed in 12 of the 20 records we reviewed.

Staff used a recognised pressure ulcer risk assessment tool, which was included in the nursing assessment notes. We looked at 18 records in which a pressure ulcer risk assessment was appropriate for the patient, and 14 had been completed. We looked at the ward manager’s audit for June 2016 and of ten patient records reviewed, all patients had skin/pressure ulcer assessments completed and documented.

The department used a combination of paper and electronic records. Paper records were scanned into the electronic system following patient discharge and paper records would then be stored for three months. Patients’ past medical notes could be accessed immediately through the computer system.

All records we reviewed had been completed in a legible manner with staff names and designations clearly written.

Medicines

The department used an automated medicine dispensing system which had two cabinets located in the majors’ area and the resuscitation room. Staff were added to the system by an administrator and gained access to dispense medicines using a fingerprint scanner. For access to controlled drugs two authorised fingerprints were required to be scanned. The pharmacy department had oversight of the system, allowing them to monitor stock levels, expiry dates and discrepancies. We checked 20 medicines at random across both cabinets and found that all were in date, with stock rotation apparent. However, some oral solutions did not have ‘opened’ dates recorded on them, so staff did not know when they would need to be disposed of. We also found that quality control solution in the blood glucose monitoring kits did not have dates written on when opened. We looked at the risk register for the department following our inspection, and it had been identified that the dispensing cabinets were registering above the temperature threshold. There was an action plan in place to monitor temperatures and find more effective ways of cooling the environment. Relocating the cabinet in the majors’ area was being considered, but this was not possible for the cabinet located in the resuscitation room.

Fridge temperatures were recorded electronically and monitored by the pharmacy department. Medicines should be stored at the correct temperature to ensure they do not become ineffective or harmful. We checked the fridges and found medicines to be in date but stored in a disorganised manner.

Intravenous medicines were stored appropriately, on labelled shelves in a cupboard locked by keypad. We witnessed staff administering medicines, both oral and intravenous, on four occasions. On each occasion this was done correctly, with medicines and patient details checked
appropriately, however we witnessed one staff member place the prepared medicines on top of a clinical waste bin meaning that they had to be disposed of and prepared again.

We found emergency drugs boxes to be sealed and labelled with the date of expiry. All were in date and maintained by pharmacy staff.

During inspection we were concerned that paper copies of patient group directions (PGDs) had not been updated and signed by nursing staff other than ENPs. PGDs are required to enable nurses to administer certain ‘prescription only’ medicines without a prescription from a doctor. We were informed during inspection that if nurses’ PGD paperwork was not up to date they would not administer medicines without a prescription from a doctor, but we could not be fully assured of this. Following inspection, we were assured by the trust that an immediate review had been completed and a rapid improvement plan was in place to address this. All PGD expiry dates were being reviewed and any that were out of date immediately acted upon. A senior nurse was appointed to attend the monthly PGD group and there was a plan to proactively review PGDs before they expired. The group would continue to meet until the action plan was completed. Packs of updated printed copies of PGDs were being distributed to each clinical area requiring them, all staff who used them had to fill in a signature sheet and they were all then signed off by a clinical lead. There was a named Matron to ensure sheets were signed and staff competencies had been completed.

**Incidents**

Staff we spoke to knew how to report incidents; they were encouraged to do so, felt supported during the process, and received feedback. They found the online reporting system easy to use.

We spoke to the department matron who reviewed all incidents reported on the department’s system. Incidents were shared in a staff diary and a closed social media group, and staff were involved in looking at reasons incidents may have occurred and what could be learned. The clinical educator for the department often used incident outcomes to influence staff teaching and training.

We looked at the incidents reported for the three months from April to June 2018. The most commonly reported incidents were pressure sores/decubitus ulcers, abuse of staff by patients, other abuse and security related incidents. We spoke to the clinical governance lead who told us that investigation of incidents forms part of the governance role, particularly those that have been reported as serious incidents or near misses. Lessons learned are disseminated to the teams through staff meetings, during handover, and in a private social media group.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke to were aware of the duty of candour and could explain it adequately to us, although none were able to give examples of when it had been applied.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for urgent and emergency care.
In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from May 2017 to April 2018. Of these, the most common types of incident reported were slips/trips/falls meeting SI criteria, with two incidents.

(SOURCE: NHS Improvement - STEIS)

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.

(SOURCE: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff were aware of policies and procedures and knew where to find them. The department used Clinical Emergency Medicine (CEM) Books; this is a secure computer application used to help
manage departments and provide guidance for staff. Staff could access CEM Books from computers or from their own smartphones, and were able to view department policies, procedures and pathways, and see the status of the department and any concerns. A situational report was updated by senior staff at regular intervals during the day.

The department participated in national RCEM audits to monitor standards of care and improve practice. Action plans were put in place based on audit result recommendations. Junior doctors in the department participated in audit activity, with governance and feedback provided by consultants.

Data provided to us by the trust gives details of a sepsis audit, driven by the national Commissioning for Quality and Innovation (CQUIN) scheme, which was completed in May 2018. The year-end data collection results from ED showed that 93% of patients were appropriately screened for sepsis. The percentage of patients who received intravenous antibiotics within the first hour was 66%; this had increased from 19.2% in the 2016-17 RCEM. Further actions following the audit included monthly feedback sessions, ongoing education of staff and launch of a sepsis awareness week in September 2018. The audit identified that sepsis awareness had improved and decreased mortality had been demonstrated, but that good documentation of the sepsis screening tool was essential. The risks identified were that there was a shortage of microbiologists to support the program, and the lack of use of the screening tool had led to poor blood culture sampling. A monthly department audit showed that, out of ten patients’ records reviewed, three were eligible for sepsis screening and none of the three had received the completed sepsis bundle.

The department’s policies were based on guidance issued by the National Institute for Health and Care Excellence; the agenda for clinical governance meetings contained a section dedicated to the discussion of new guidance and whether or not it was applicable to the department. Pathways in use in the department included falls, pressure area care, stroke, sepsis, fractured neck of femur and mental health.

Staff in the ED were supported to care for patients presenting with mental health conditions by a psychiatric liaison team employed by the local mental health trust. Staff from the psychiatric liaison team had access to the mental health trust’s care records, so could identify if patients were known to mental health services and give details of community mental health input and current treatment regimes. This was done on a ‘need to know’ basis to help ensure patients presenting with mental health conditions at the emergency department received appropriate and continuous treatment. The psychiatric liaison team gave verbal information to emergency department staff but no written management plan was available.

We were concerned that paper copies of PGDs had not been updated and signed by nursing staff other than ENPs. We were informed during inspection that if nurses’ PGD paperwork was not up to date they would not administer medicines without a prescription from a doctor, but we could not be fully assured of this. Following inspection, we were assured by the trust that an immediate review had been completed and a rapid improvement plan was in place to address this. All PGD expiry dates were being reviewed and any that were out of date immediately acted upon. A senior nurse was appointed to attend the monthly PGD group and there was a plan to proactively review PGDs before they expired. The group would continue to meet until the action plan was completed. Packs of updated PGDs were being distributed to each clinical area requiring them, all staff who used them had to fill in a signature sheet and they were all then signed off by a clinical lead. There was a named Matron to ensure sheets were signed and staff competencies had been completed.

Nutrition and hydration

We spoke to 12 patients and six told us that they had been offered something to eat and drink. Two said they had not been offered anything, and the remaining four had only been in the
department for a short time. We witnessed several patients being offered food and drink by staff and two patients who asked for drinks who were attended to immediately.

After reviewing patients’ records we saw that comfort rounds, which were part of the ED checklist and included patients being offered food and drink, were completed inconsistently. We reviewed 20 sets of patients’ notes and seven had documentation completed to say they had been offered food or drink. We spoke to a housekeeper, working between the adult and children’s ED, who said that they would routinely check with staff which patients were able to eat and drink, and ask these patients whether they required anything. They could request food if it wasn’t readily available in the department, and were able catered for specialised diets. The housekeeper told us they were not responsible for documenting this in patients’ notes. We saw audits relating to the presence of ED checklists in patients’ notes, but nothing specifically relating to nutrition and hydration.

In the waiting room there were vending machines available for patient use, with healthy drink and snack options available. There were jugs of water available around the department for patient/visitor use, and these were labelled by staff when they were changed or refilled.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey – September 2016)

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.4 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey - September 2016)

We spoke to 12 patients and they all told us that staff had ensured they were comfortable. Seven recalled having been specifically asked to score their pain. We reviewed 20 sets of adult patients’ notes and pain scores were recorded in 14 out of 20. We reviewed 23 sets of children’s notes and pain scores had been completed in seven.

Patient outcomes

The RCEM has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimal clinical outcomes. The emergency department had participated in several audits to benchmark their performance against the CEM standards

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Moderate and acute severe asthma report, Pinderfields Hospital emergency department failed to meet any of the standards.

The department was in the upper UK quartile for two standards:
• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  o Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 39.3%; UK: 19%.

• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  This department: 72%; UK: 52%.

The department was in the lower UK quartile for two standards:

• Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 12%; UK: 19%.

• Standard 3 (fundamental): High dose nebulised β₂ agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 9%; UK: 25%.

The department’s results for the remaining four standards were all between the upper and lower UK quartiles:

• Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 30%; UK: 26%.

• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β₂ agonist bronchodilator therapy. This department: 76%; UK: 77%.

• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  o Standard 5b (fundamental): within 4 hours (moderate). This department: 26.2%; UK: 28%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Pinderfields Hospital emergency department failed to meet any of the standards.

The department was in the upper UK quartile for one standard:

• Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged
30 years and over. This department: 28%; England: 11%.

The department was in the lower UK quartile for one standard:

- **Standard 3** (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 4%; UK: 12%.

The department’s results for the remaining two standards were all between the upper and lower UK quartiles:

- **Standard 2** (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 12%; UK: 8%.

- **Standard 4** (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 4%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Pinderfields Hospital emergency department was in the upper UK quartile for one standard:

- **Standard 3**: \(O_2\) was initiated to maintain \(SaO_2 > 94\%\) (unless there is a documented reason not to) within one hour of arrival. This department: 61%; UK: 30.4%.

The department was in the lower UK quartile for two standards:

- **Standard 6**: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 23.2%; UK: 43.2%.

- **Standard 7**: Antibiotics administered: Within one hour of arrival. This department: 19.2%; UK: 44.4%.

The department’s results for the remaining five standards were all between the upper and lower UK quartiles:

- **Standard 1**: Respiratory rate, oxygen saturations (\(SaO_2\)), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 51.5%; UK: 69.1%.

- **Standard 2**: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 51.5%; UK: 64.6%.

- **Standard 4**: Serum lactate measured within one hour of arrival. This department: 43%; UK: 60%.

- **Standard 5**: Blood cultures obtained within one hour of arrival. This department: 33.7%; UK: 44.9%.

- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of
arrival. This department: 12.2%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16 (Pinderfields Hospital)

In the 2015/16 Vital signs in children audit, Pinderfields Hospital failed to meet any of the standards.

The department was in the upper England quartile for one fundamental standard and one developmental standard:

- Standard 1. All children attending the emergency department with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  - Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. This department: 52%; England: 37.6%.
  - Standard 1b (developmental). Capillary refill time. This department: 43%; England: 22.5%.

The department’s results for the remaining four standards were all between the upper and lower England quartiles.

- Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. This department: 9.8%; England: 4.4%.

- Standard 3 (developmental). There should be explicit evidence in the emergency department record that the clinician recognised the abnormal vital signs (if present). This department: 62.8%; England: 69.7%.

- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. This department: 58.8%; England: 73.2%.

- Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). This department: 66.7%; England: 60%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16 (Pinderfields Hospital)

In the 2015/16 Procedural sedation in adults audit, Pinderfields Hospital emergency department failed to meet any of the audit standards (which were all 100%).

The department was in the lower England quartile for one standard:

- Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - Standard 7a. (fundamental): Return to baseline level of consciousness.
Standard 7c. (fundamental): Absence of respiratory compromise.
Standard 7d. (fundamental): Absence of significant pain and discomfort.
Standard 7e. (developmental): Written advice on discharge for all patients.

This department: 0%; England: 2.6%.

The department’s results for the remaining six standards were all between the upper and lower England quartiles.

• Standard 1 (fundamental): Patients undergoing procedural sedation in the emergency department should have documented evidence of pre-procedural assessment, including:
  o Standard 1a. ASA grading
  o Standard 1b. Prediction of difficulty in airway management
  o Standard 1c. Pre-procedural fasting status
This department: 1.3%; England: 7.6%.

• Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. This department: 46.8%; England: 51.8%.

• Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. This department: 78.8%; England: 90%.

• Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  o Standard 4a. A doctor as sedationist
  o Standard 4b. A second doctor, ENP or ANP as procedurist
  o Standard 4c. A nurse
This department: 52.5%; England: 40.8%.

• Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  o Standard 5a. Non-invasive blood pressure
  o Standard 5b. Pulse oximetry
  o Standard 5c. Capnography
  o Standard 5d. ECG
This department: 10%; England: 23.9%.

• Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. This department: 35%; England: 41%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16 (Pinderfields Hospital)

In the 2015/16 Venous thrombo-embolism risk in lower limb immobilisation in plaster cast audit Pinderfields Hospital emergency department met one of the two audit standards (which were both 100%).
The department was in the upper England quartile for one of the two standards:

- **Standard 1 (fundamental):** If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. This department: 100%; England: 100%.

The department was in the lower England quartile for one of the two standards:

- **Standard 2 (developmental):** Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. This department: 0%; England: 2%.

(Source: Royal College of Emergency Medicine)

This audit was completed in 2015-16, at that time there was no pathway for lower limb immobilisation and VTE. Since then the trust has confirmed and provided evidence to demonstrate that work has been undertaken on this pathway, with the development of a clear protocol and advice leaflet for patients with lower limb immobilisation.

Following inspection, the trust provided us with further data relating to the most recent RCEM audits, which were:

- **Procedural sedation in adults 2017/2018** – the department failed to meet any of the RCEM standards. Of the 12 standards recorded one was in the upper quartile, four were between the upper and lower quartiles and the remaining seven were in the lower quartile. 10 results were below the UK average and two were above.

- **Fractured neck of femur 2017/2018** – the department met one of the RCEM standards: 75% of patient should have and x-ray within 120 minutes of arrival. Of the nine standards recorded, all fell between the upper and lower quartiles; two were above the UK average, two were the same and five were below.

- **Pain in children** – the department met two of the RCEM standards:
  - **Standard 2:** Patients in severe pain (pain score 7 to 10) should receive appropriate analgesia, according to local guidelines (50% within 20 minutes of arrival).
  - **Standard 3:** Patients with moderate pain (pain score 4 to 6) should receive appropriate analgesia in accordance with local guidelines (50% within 20 minutes of arrival).

  Of the six standards recorded, four were above the UK average and two were below.

The trust provided us with evidence of action plans based on the recommendations from the procedural sedation and fractured neck of femur audits; the pain in children action plan was still in development at the time of our inspection.

Unplanned re-attendance rate within seven days

From April 2017 and March 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.

In March 2018, trust performance was 8.7% compared to an England average of 7.6%.

Unplanned re-attendance rate within seven days - The Mid Yorkshire Hospitals NHS Trust
Local audits were also carried out bi-monthly. These were done by the matron from Dewsbury ED to prevent bias, and included triage assessment, pain management, NEWS recording, sepsis management, falls prevention, pressure ulcer prevention, patient dignity and ED environmental checks. The department was 90-100% compliant in many areas; the exceptions were triage and pain assessments (both 60%), analgesia administration and follow-up (70-80%) and four aspects of sepsis bundle management (70-80%).

**Competent staff**

**Appraisal rates**

**Trust wide**

The trust target for staff appraisal completion rate was 85%. From April 2017 to March 2018, 78% of required staff across the trust’s urgent and emergency care services received an appraisal. Data provided to us following inspection showed the appraisal rate had increased to 95%, which showed a marked improvement. The trust was unable to provide site- or role-specific data. Staff we spoke to on inspection told us that their appraisal had been completed. They had found it helpful and felt supported in the process.

New staff starting work in the department had a six-week induction plan which had been devised by the clinical practice educator. Each week had specific objectives and clinical time was allocated to work with a specified preceptor; this is an experienced practitioner who provides supervision and guidance. We spoke to two staff who had undergone the induction programme and they had found it very positive and supportive.

The department had a clear education strategy in place, with objectives for each level of nursing and care support staff. We were told that funding was not available for nursing staff to complete the advanced life support (ALS) or trauma nursing core course (TNCC) courses; the department had attempted to mitigate this by devising an ‘arrest course’ for staff in which they were presented with various patient care scenarios to manage, and which involved a board game to encourage learning and improve staff engagement. The department also accessed the Trauma and Resuscitation Team Skills (TARTS) course and training from external providers, for example medical technology companies, also took place.
Mental health training was not mandatory for nursing staff although some ad-hoc training was available and was provided by the psychiatric liaison team (PLT). There was a care certificate course for new healthcare assistants (HCAs) which had a component, delivered by the PLT, around the management of challenging behaviour.

The children’s department had a practice facilitator and there was an action plan in place to ensure children’s nurses were appropriately qualified and experienced. We saw evidence of a clear education plan for the year ahead. Data provided to us by the trust showed that 73% of eligible paediatric ED staff were compliant with Paediatric Immediate Life Support (PILS) training and 60% were compliant with European Paediatric Advanced Life Support (EPALS). The trust target was for 85% training compliance by February 2019, and we were informed that 100% of eligible staff had been enrolled on courses. There were at least two registered children’s nurses on duty in the children’s ED at all times.

The department had a local induction process in place for agency staff and it was possible for them to have access to systems such as the computer databases and medicine dispensing facility. We were told that often the same agency staff returned to the department, so were familiar with the environment, policies and procedures. We spoke to two agency staff who told us they regularly worked shifts at Pinderfields and felt the induction process had been very good. They both enjoyed working in the department, felt well supported by colleagues and found senior staff helpful and approachable.

The trust’s ENPS rotated across the three hospital sites and told us this was useful to provide insight into issues and challenges in the different areas. There were 28 ENPs employed, nine of which were independent prescribers. The other ENPs all had up to date PGDs and this was monitored by the trust ENP lead. Appraisals were also up to date.

The ANPs had allocated time for professional development and attended teaching sessions facilitated by medical staff. They told us they felt well supported to learn and develop. There was an ED lead responsible for medical training provision; the training plan involved a three-day induction plus two days of emergency medicine specific training. This had gained positive feedback from Leeds University.

Nursing staff told us they were well supported through revalidation completion. Revalidation is the process that all nurses and midwives in the United Kingdom need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing.

Multidisciplinary working

We observed good examples of teamwork within the department; doctors, nurses and other healthcare professionals working well together to support each other and to provide effective patient care. There was good communication and staff we spoke to told us they felt part of a team. Board rounds were held twice daily in which staff from different disciplines came together to discuss the status of the department and any issues or challenges.

Several staff reported problems when requesting doctors from other specialities, such as orthopaedics and surgery, to review patients in the ED; we were told that speciality doctors were not always willing to attend and when they did their responses weren’t always timely. This is not in line with trust policy. However, staff also reported good examples of referral systems working well: we were told that the cardiac specialist nurses were very responsive and supportive, and they regularly attended the department to review patients. We spoke to ENPs who told us that they had good working relationships with orthopaedic and ophthalmic (eye) doctors, and with the plastic surgery team. They gave examples of these teams providing support and training to staff.
We spoke with an occupational therapist (OT) from ‘Team One’, a team in place as part of a pilot project consisting of OTs and physiotherapists, who identified patients in ED who they thought may need assistance upon discharge, without waiting for referral from ED staff. They attended the department and performed an assessment of the patient’s needs and abilities, then if appropriate arranged further assessment, assistance or equipment with the aim of providing an easier and more seamless discharge process.

We witnessed good examples of team working between the adults' and children’s departments, and were told by staff in the children’s ED that they also worked effectively with staff on the children's assessment unit and children’s ward.

Staff in the emergency department received specialised support from the psychiatric liaison team who worked 24 hours a day, 7 days a week with all adult patients who presented to the emergency department. They were based within Pinderfields and Dewsbury hospitals during the day and were based at Pinderfields hospital at night. Staff within the psychiatric liaison team and emergency department highly valued each other’s input and commented that the services worked well together to meet patients’ physical and mental health needs.

We spoke with ambulance staff who told us they had good working relationships with ED staff, and they all worked together to support and assist each other.

**Seven-day services**

The ED was operational 24 hours a day, seven days a week, and access to services such as X-ray/CT scanning facilities, pharmacy and pathology was available at all times, either through direct referral or on-call. There was 24 hour a day access to PLT for adults, which we were told was very responsive, but staff indicated that the child and adolescent mental health service (CAMHS) provided an out of hours on call service which was not as responsive.

**Health promotion**

We saw posters in the waiting room giving information to patients about access to local walk in centres. There was information available in the department about smoking cessation services and access to alcohol liaison teams. We saw information leaflets for patients, for example giving advice about aftercare following treatment, and these could be accessed in other languages. Discharge advice was given to patients / carers to allow patients to safely manage their condition at home or where to seek further advice if appropriate.

Healthy drink and snack options were available to patients in the waiting room vending machines.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

We were told by staff that verbal consent was routinely obtained from patients but would not usually be documented. We witnessed staff explaining procedures to patients and gaining their consent verbally. Staff told us that they would document if a patient refused to provide consent or if they did not have capacity to make a decision, and this would be escalated. Staff we spoke to demonstrated good knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in relation to their role. We reviewed 20 sets of adult patient notes and one had the patient’s mental capacity recorded. Two further sets of notes stated that the patient had dementia but did not have mental capacity recorded.

In the children’s ED, the staff we spoke with were aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The 'Gillick Test' helps clinicians to identify if children under 16 years of age have the
legal capacity to consent to medical examination and treatment. They must be able to
demonstrate sufficient maturity and intelligence to understand the nature and implications of the
proposed treatment, including the risks and alternative courses of actions. The Fraser guidelines
are used specifically to decide if a child can consent to contraceptive or sexual health treatment
and advice.

Mental Capacity Act and Deprivation of Liberty training completion

MCA and DoLS (combined) level 1 training was part of the trust’s mandatory training programme,
to be completed three yearly, with a compliance target of 95%. Data provided to us by the trust
showed that in urgent and emergency care training compliance was 99%

MCA and DoLS levels 2 and 3 were part of the trust’s role specific training programme, both to be
completed every three years with a completion target of 85%. Data provided to us by the trust
showed that, in urgent and emergency care, level 2 compliance was 77% and level 3 compliance
was 52%. The trust was unable to provide role or site-specific data.

Is the service caring?

Compassionate care

We found friends and family test information readily available around the department, and
separate information was also available in the children’s ED. We witnessed staff asking patients to
complete the survey and providing them with the relevant information, and spoke to several
patients and relatives who had already completed it whilst in the department.

We observed many interactions between staff, patients and others (for example carers and
relatives) during our inspection. At all times we found staff to be polite, respectful, professional and
non-judgmental in their approach. All staff grades were seen to introduce themselves to patients,
and to ask what the patient preferred to be called. We observed staff responding to patients’
needs in a compassionate and timely manner; the patients we spoke to all had call bells available
and those that had needed to summon assistance said they had not had to wait long before a
member of staff attended. Staff closed the curtains and doors of cubicles when patients were
receiving care and treatment.

We observed an ambulance crew ask to hand over a patient in private; they were directed by a
nurse into a separate cubicle and the patient was involved in the process. We had concerns about
the privacy and dignity of some patients, particularly in the ambulance waiting area, which became
overcrowded during busy times with no evidence of privacy screens being used. Ambulance staff
told us they were sometimes required to wait on the corridor near the ambulance entrance; we
witnessed many people using the corridor to access other areas of the hospital due to the
ambulance entrance being unsecured. During inspection, we witnessed ambulance patients being
transported to the resuscitation room through the majors’ reception area, and were concerned that
their privacy was also compromised. Following inspection, the trust has provided assurance that
this would only occur if an ambulance crew had not recognised the need for resus and were
directed there by the ambulance handover nurse; there was a second entrance into the majors’
area which allowed direct access to the resuscitation room.

We reviewed monthly audits which included a section on patient dignity; ten patients’ records were
reviewed during the audit and looked at whether the patient had a call bell in reach, if patients’
modesty was maintained, if preferred names were documented and if the patients were aware of
their named nurse. Each category audited was 100% compliant.
Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from April 2017 to March 2018.

In March 2018 the trust performance was 94.6% compared to the England average performance of 84.3%.

A&E Friends and Family Test performance - The Mid Yorkshire Hospitals NHS Trust

(\text{Source: NHS England Friends and Family Test})

Emotional support

We observed staff providing effective emotional support to several patients who were anxious. We witnessed an interaction between a staff member and a patient’s relative who had become very distressed and had left the department; the staff member remained calm, providing explanation and reassurance to the relative, who was then able to return to the department and was heard to thank the staff member for their assistance.

There was multi-faith support available to patients within the hospital, and to families and carers following bereavement. The department had two private rooms, adjacent to the resuscitation room, that could be used by people such as family and friends of patients in the resuscitation room. We saw that written bereavement support and advice was available and could be accessed in other languages.

Understanding and involvement of patients and those close to them

We spoke to twelve patients and four relatives, and all said they had felt involved in their care and were helped to make informed decisions. This included parents being involved in their child’s care in the children’s ED. Patients told us that staff had made sure they understood what was happening and kept them updated during their time in the department, for example if they were waiting for further assessment or test results.

We observed nursing and medical staff explaining procedures to patients clearly and using appropriate language, whilst remaining respectful. Advice was given to patients when they were
discharged and we observed nursing and medical staff ensuring this was understood by patients and relatives.

Emergency Department Survey 2016

The trust scored “better than” other trusts for none of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored “worse than” other trusts for one question and “about the same” as other trusts for the remaining 23 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department,</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>did you get the results of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

Is the service responsive?

Service delivery to meet the needs of local people

Following the reconfiguration of services, the ED at Pinderfields Hospital had become the main receiving department for acutely unwell patients and those with complex needs. Staff told us that many patients had said they were unhappy about this as they lived nearer to either Pontefract or Dewsbury Hospital and would have preferred to attend there. Patients could be discharged to another hospital for follow-up care if their treatment requirements were appropriate, and there was a free shuttle bus providing transport between the trust’s three hospital sites.

The trust had an agreement in place with Age UK to assist with patient discharges for those who met the appropriate criteria.

The trust was working with the local authority to identify increases in ED attendance from patients in certain local areas, and to identify possible reasons for this.

Local people attending the ED with mental health needs were referred to the psychiatric liaison service, who aimed to attend within an hour of referral, but mental health services for children and young people in the local area were less responsive. The psychiatric liaison service was commissioned by the local clinical commissioning group as part of the mental health contract. The service specification set out the level of support to be provided to the trust. It included support to adults of all ages including older people, but not children and young people.

Staff from the emergency department, the psychiatric liaison team, police and other services met regularly to discuss supporting people who frequently attended the emergency department, including patients with mental health needs. Staff also looked at redirecting patients from the emergency department if their needs could be better met elsewhere in the health and social care...
system. For example, a patient was re-housed in supported accommodation to meet their social needs, with the aim of preventing inappropriate attendances to the emergency department.

Meeting people’s individual needs

Patients who attended the department who were known to be living with dementia or learning disabilities were flagged on the computer system. The VIP scheme was used to identify and support patients with learning disabilities; this was a system used to ensure staff were aware of important patient information and requirements. Patients living with dementia were identified by a forget me not symbol. This was used to alert staff that extra support may need to be provided. The trust employed liaison nurses for learning disabilities and dementia, and staff could refer to them for advice or additional support for patients. We were told by staff in the department that they were hoping to secure funding for ‘dementia friendly’ cubicles, but this had not been approved at the time of inspection. Distraction aids were available for use by patients to help minimise agitation and anxiety.

Interpretation services were available for patients by telephone, and we saw posters around the department and in the waiting room giving information about this service. Patient advice leaflets could be requested in other languages. We were not made aware of any other communication aids available, and it was not apparent that patient flagging occurred for those with communication needs.

In the children’s ED there was a designated breastfeeding room for people who required privacy. There was a children’s play specialist employed by the trust; using play can help children understand their injury or condition, provide a distraction to relieve anxieties, and contribute to assessment and diagnosis.

The department was accessible for people with mobility problems or those using wheelchairs. Accessible toilets were also available. Wi-Fi access was available for patients and visitors. The department had access to bariatric equipment, including chairs, wheelchairs and portable/ceiling hoists.

Emergency Department Survey 2016

The trust scored “about the same as other trusts” for the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

Access and flow

Staff told us that they felt the department had become much busier since AHR and not enough consideration had been given to how the department would cope with the increased demand. They said the pressures over winter had been particularly bad, with an increase in ambulance attendances due to the changes at Dewsbury Hospital. We were told the department had often
become overcrowded and there were regular delays in bed availability in the hospital; this resulted in patients having to wait in the ED when they had been referred directly for ward admission but no bed was available. Despite this many staff told us that they were proud of the fact that ambulance handover times had improved and thought the introduction of a designated ‘flow nurse’ in the department had contributed to this. Senior staff conducted board rounds twice daily to discuss the flow in the department, and this was regularly updated on CEM Books. We spoke with six ambulance staff who each said that they felt their waiting time to handover had generally reduced. The department had two porters to assist with movement of patients to wards and other areas.

We spoke with the patient services manager who had daily oversight of the department from an operational perspective, looking at quality, performance and risk alongside clinical leads. We were told there were four divisional operational meetings each day to discuss these issues and to plan where support was needed. A daily operational performance meeting took place each morning, with teleconference links to Dewsbury, which was attended by each division to assess issues of capacity, demand and operational challenges.

The trust had an operational pressures escalation procedure which described the management during both ‘normal business’ and times of increased demand. The aim of this was to provide a high level of patient care to the public, including at times when the trust was experiencing capacity pressures and periods of high demand. The policy gave details of the structure of daily operational performance meetings, and of the expectations and responsibilities of each division within the hospital.

Within the document there was a section highlighting ten principles for effective emergency care. These included: speciality assessment of patients within 30 minutes of referral; patients referred from primary care to be transferred directly to the most appropriate speciality unless immediate medical intervention was required; no speciality doctor to refuse a request to assess a patient in ED and no patient to be transferred to another hospital’s ED within the trust unless ongoing care in the resus room is required. We were told on inspection that these principles were not always followed: doctors from other specialities were asked to review patients in the department and were often reluctant to attend or their responses were not timely, and patients referred from Dewsbury hospital or primary care were often transported to Pinderfields ED when there was no bed available elsewhere. Specialty review issues were documented as being discussed at a weekly performance meeting in July 2018, as they had been identified as a cause for several delays per month in ED, and this was followed up for discussion at a rapid process improvement workshop in order to develop an agreement between services.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for eight months over the 12-month period from April 2017 to March 2018.

From April 2017 to March 2018 performance against this standard showed performance similar to the England average.

In March 2018 the median time to treatment was 65 minutes compared to the England average of 64 minutes.

**Median time from arrival to treatment from April 2017 to March 2018 at The Mid Yorkshire Hospitals NHS Trust**
We reviewed 20 patients’ records and noted the amount of time from arrival to treatment. Ten patients were seen within one hour by a doctor or ENP. A further five patients were seen within two hours. Five patients were seen between two and four hours.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From April 2017 to March 2018 the trust failed to meet the standard and performed worse than the England average for nine of the 12 months in this period.

From April 2017 to March 2018 performance against this metric showed no consistency and a gradual decline in performance.

Four-hour target performance - The Mid Yorkshire Hospitals NHS Trust

(Source: NHS England - A&E Waiting times)

We reviewed 20 sets of patients’ records and 15 were admitted, transferred or discharged within four hours.

Percentage of patients waiting more than four hours from the decision to admit until being admitted
From April 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From April 2017 to March 2018 performance against this metric showed little consistency but an overall increase in the percentage of patients waiting by the end of the period.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - The Mid Yorkshire Hospitals NHS Trust


We looked at 20 patients’ records during our inspection; five of these patients were admitted to hospital. One of these patients had waited more than four hours from the decision to admit until being admitted.

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from April 2017 to March 2018, three patients waited more than 12 hours from the decision to admit until being admitted. The only patients waiting over 12 hours were in May 2017 and December 2017 and February 2018.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>367</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>1,037</td>
<td>1</td>
</tr>
<tr>
<td>Jun-17</td>
<td>684</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>1,020</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>1,146</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>835</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,144</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>481</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1,414</td>
<td>1</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,943</td>
<td>0</td>
</tr>
<tr>
<td>Feb-18</td>
<td>772</td>
<td>1</td>
</tr>
</tbody>
</table>
Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

From April 2017 to March 2018 the monthly median percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was similar to the England average.

From April 2017 to March 2018 performance against this metric showed a stable trend.

In March 2018 the median percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 4.1%, compared to the England average which was 3.3%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - The Mid Yorkshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From April 2017 to March 2018 the trust’s monthly median total time in A&E for all patients was similar to the England average.

From April 2017 to March 2018 performance against this metric showed a small increase in the median total time in A&E per patient.

In March 2018 the trust's monthly median total time in A&E for all patients was 152 minutes compared to the England average of 160 minutes.
Median total time in A&E per patient - The Mid Yorkshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 176 complaints about urgent and emergency care services. The trust took an average of 27 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 days.

The four most common subjects of complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Percentage of total complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>61.4%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>19.9%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>6.3%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018 there were 133 complaints about urgent and emergency
care services at Pinderfields Hospital.

The four most common subjects of complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Percentage of total complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>61.7%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>20.3%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>7.5%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were 110 compliments in urgent and emergency care.

<table>
<thead>
<tr>
<th>Name of hospital</th>
<th>Total number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dewsbury &amp; District Hospital</td>
<td>43</td>
</tr>
<tr>
<td>Pinderfields Hospital</td>
<td>59</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The department had a process in place for dealing with complaints from both a medical and nursing perspective. The department matron handled the nursing related complaints, and the deputy clinical director for the medicine division handled complaints related to medicine. All complaints were discussed at monthly clinical governance meetings, along with lessons learned and actions required. We were told that the department aimed to keep the complaints process as informal as possible, by speaking with those involved and being open and honest. As with incidents, complaints were shared with staff and used to influence learning and education.

We saw information displayed in the department giving details of the patient advice and liaison service (PALS) and informing patients how to make a complaint if they wished to. Staff we spoke to told us how they would handle a complaint or concern and told us that complaints had been shared with staff to learn from them.

Is the service well-led?

Leadership

Staff told us that the department management team was approachable and supportive, and that there was a visible management presence in the department. Staff also commented that the chief executive visited the department regularly and discussed concerns with them.
The nursing team in the department was led by experienced staff who provided clinical and professional supervision. There was an education strategy for the department which gave clear objectives for staff at every level, and this included development of leadership skills for more experienced staff.

We observed clear leadership in the department’s medical team; on several occasions we witnessed junior doctors being supported by more senior colleagues and consultants, with teaching discussions taking place and feedback and advice being given. We spoke with junior doctors who told us they were happy with the leadership within the department and they felt well supported.

**Vision and strategy**

The trust’s vision and values were clearly displayed around the hospital and in the department. When we asked staff about the strategy for the department most were unclear. This included senior staff. Two members of staff commented that they felt unable to comment on a strategy for the department because of the changes that were occurring following AHR; they felt the department was still evolving and would continue to do so for some time. Some thought the department would become more specialised, with a focus on acutely unwell medical patients.

**Culture**

We spoke with senior staff in the department who were experienced and professional, and made it clear to us that they were proud of the department and staff despite the challenges they faced. The staff we spoke to told us that the culture in the department was open and inclusive; staff felt valued and respected, and wanted to be there. Some staff told us that morale had been quite low following AHR and the winter pressures, but that things had improved and that they had all supported each other and worked well as a team. We were told by several staff that it felt as though AHR had happened ‘overnight’ and they hadn’t been consulted about it or asked what their concerns would be.

The senior staff spoke highly of their team and we witnessed positive examples of teamwork and support during our inspection. One staff member told us they had recently required psychological support following an incident. This was arranged through the department and the staff member said they had felt well supported and that their welfare mattered. We spoke to another staff member who had recently been supported through a return to work programme, who told us this had been individually planned and very helpful.

**Governance**

The ED was part of the medical directorate, which had clear governance structures with a deputy head of nursing, deputy director of operations and head of clinical services. There were two consultants responsible for governance within Pinderfields ED. Each speciality within the directorate had a designated governance lead; regular meetings ensured that information was shared with each area and fed up to the quality committee, patient safety panel and trust board as necessary. The ED had monthly clinical governance meetings, with a telephone conference link to Dewsbury and Pontefract Hospitals, to which all staff were invited. These meetings provided an opportunity to discuss issues such as patient safety and risk management, and to present information to the teams, such as the latest audit information and guidance.

The trust had signed up as a partner agency to the local mental health crisis care agreement and action plan for the Wakefield area. This was a national agreement between services and agencies
involved in the care and support of people in mental health crisis. It set out how organisations would work together better to make sure that people got the help they needed when they were having a mental health crisis.

**Management of risk, issues and performance**

The department had a clear business management plan and operational pressures escalation policy, which gave detail of ‘normal’ business management and the actions to be taking when service demand was increased.

The department had a patient services manager, who was relatively new in post at the time of our inspection, and who had oversight of the three hospital sites looking at quality, risk and performance alongside the senior management team. At Pinderfields there was a daily operational performance meeting involving staff from all divisions, and four daily divisional operations meetings, looking at bed availability, concerns and actions that needed to be taken. The patient services manager made daily visits to the ED, along with the department matron, to identify risks and issues. We were told on inspection that the department was planning to introduce regular, structured multi-disciplinary safety briefings within the department but it was not known when this would happen. The management team were also aware of the potential safety issues in relation to the layout of the department and we were told they were looking at ways in which this could be improved, including the introduction of a tannoy system for use by staff.

We asked senior staff what the main risks were in the department, and they told us that nurse staffing, overcrowding and patient outflow from the department were the biggest risks. Following our inspection, we looked at the department risk register dated 31 July 2018, and nurse staffing had not been identified as a risk, however it was highlighted by most staff we spoke to that nurse staffing levels often felt unsafe. Overcrowding in the department had been on the risk register since April 2015, but had been updated since AHR with details of flow challenges, bed waits and concerns for patient safety. Violence and aggression was a longstanding risk, and despite some staff telling us there weren’t many incidents occurring in the department, it was the second highest reported category of incident in the data we examined.

**Information management**

The department collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The information was used to monitor the performance of the department, and performance data was shared with staff through the CEM Books computer application. Information governance training was part of the trust’s mandatory training programme, to be completed on a yearly basis and with a 95% compliance target. Data provided by the trust showed that compliance for urgent and emergency care staff was 70% across the three hospital sites.

During our inspection we had concerns relating to the management of sensitive information. We observed patients being transferred from the department to other areas with their medical notes resting on their legs, and personal information clearly visible. We also found several computers in the department which had not been locked by the previous user and patient information was visible when the screens were activated.

We were informed during inspection that the reception staff worked across all three hospital sites and because of this had mistakenly booked patients in as being at the wrong hospital. We were told that this had always been quickly highlighted, and had never caused issues or been reported as an incident.
Engagement

The staff we spoke to provided mostly positive feedback about their roles and about the department in general. However, staff from all levels stated that there had been no engagement or involvement regarding AHR. This, along with the pressures faced over the winter months, had affected morale of staff, which had been reflected in the staff survey. We were told at the time of inspection that an independent staff psychological survey had been conducted in the department, but the results were not available at that time. It was generally felt amongst staff that low morale had started to improve. Staff appeared engaged in department activities, and told us they were involved in meetings, social media groups and social events.

We saw information around the department relating to the friends and family survey, and witnessed patients and relatives completing the survey whilst they were in the department. ‘You said, we did’ information was displayed, which showed changes that had been made following suggestions from patients.

Learning, continuous improvement and innovation

The department had a lead clinical educator, who was relatively new in post at the time of inspection, and who we spoke to about improvements in training and education within the department. We were told that the previous challenges had been recognised and there was now more emphasis on the importance of training. The department had a clear education strategy in place, and learning from incidents and complaints was embedded. Staff told us that access to training had improved and they felt better supported to learn and develop their skills.
Medical care (including older people’s care)

Facts and data about this service

There are 693 medical inpatient beds located across three sites and 26 wards/units.

A site breakdown can be found below:

- Pinderfields Hospital: 494 beds are located within 19 wards/units
- Dewsbury and District Hospital: 157 beds are located within six wards/units
- Pontefract Hospital: 42 beds are located within one ward/unit

(Source: Routine Provider Information Request – Sites tab)

The trust had 71,024 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 33,778 (47.6%), 786 (1.1%) were elective, and the remaining 36,460 (51.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 17,571
- Gastroenterology: 10,966
- Geriatric medicine: 9,183

(Source: Hospital Episode Statistics)

The services offered at Pinderfields Hospital include: acute and emergency medicine, a dedicated frailty unit, general and specialist care in gastroenterology, cardiology, respiratory medicine, diabetes and endocrinology. There is a specialist stroke unit including a hyper-acute stroke unit (HASU) and dedicated oncology and haematology services.

The trust flow pathway sees patients transfer out to Dewsbury and District Hospital and Pontefract Hospital once patients are deemed medically stable. However there is direct access to a frailty unit on the Dewsbury and District Hospital site for the benefit of the local population. The trust currently runs emergency ambulatory care services from both Pinderfields Hospital and Dewsbury and District Hospital.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 71,024 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 33,778 (47.6%), 786 (1.1%) were elective, and the remaining 36,460 (51.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 17,571
- Gastroenterology: 10,966
- Geriatric medicine: 9,183

(Source: Hospital Episode Statistics)
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed their training. Staff were required to complete core and role specific mandatory training in topic areas such as health and safety, infection control, manual handling and information governance.

Ward managers were able to tell us what the current compliance levels were for the ward and they had access to individual reports for the staff they managed. For example, the overall compliance for the acute assessment unit was 69%, the acute frailty assessment unit was 90% and for Gate 31A and B compliance was at 90%.

Staff we spoke with said they were able to access training sessions and could attend a full day of mandatory and statutory training which covered several topics.

Ward managers told us that staff were not able to progress to the next pay increment if they were not up to date with their core mandatory training.

Mandatory training completion rates

The trust set a target of 95% for completion of core mandatory training and 85% for completion of role specific mandatory training.

Information provided by the trust on 30 June 2018 showed that the overall compliance rates with core mandatory training for staff working in medical care services was 89% which did not meet the trust target of 95%.

For role specific training, overall compliance rates were 76% which did not meet the trust target of 85%.

Trust level

Core MAST Compliance (target 95%)

<table>
<thead>
<tr>
<th>CORE SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Diversity Awareness - Once in Employment</td>
<td>99</td>
<td>1538</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Infection Control - Every 2 Years</td>
<td>266</td>
<td>1331</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 1 Theory - Every Three Years</td>
<td>129</td>
<td>1468</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 1 - Every 3 years</td>
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<tr>
<td>NHS</td>
<td>MAND</td>
<td>Fire Safety - 1 Year</td>
<td>422</td>
<td>175</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Health and Safety Level 1 - 3 Years</td>
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<td>1505</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>416</td>
<td>1181</td>
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<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 1 - 3 Years</td>
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<td>1488</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>96</td>
<td>1501</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1601</td>
<td>12772</td>
<td>14373</td>
<td>89%</td>
</tr>
</tbody>
</table>
Role Specific Compliance (target 85%)

Safeguarding

Staff had a good knowledge and understanding of the trust’s safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff knew how to contact the safeguarding team for advice and had access to the team’s details on the intranet. Information on safeguarding with flowcharts for staff to follow, were also available on the intranet.

Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children.

Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the medical wards.

Staff told us that the Mental Health Act was rarely used. Their understanding of the Act was not clear and some staff confused it with the Mental Capacity Act 2005.

Safeguarding training completion rates

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module.

Trust level

The trust provided a breakdown of compliance on 30 June 2018 for safeguarding training modules for staff working in medical care.

Role Specific MAST Compliance (target 85%)

<table>
<thead>
<tr>
<th>ROLE SPECIFIC SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Blood Transfusion Safety - Every Two Years</td>
<td>292</td>
<td>774</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Conflict Resolution - Once in Employment</td>
<td>296</td>
<td>1036</td>
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<td>377</td>
<td>LOCAL</td>
<td>Consent</td>
<td>21</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Health and Safety Level 2 - Every 2 Years</td>
<td>235</td>
<td>881</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 2 practical - Every Three Years</td>
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<td>755</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Health and Safety Level 1 - Every Three years</td>
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<td>27</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Medicines Management Level 2 - Every Three Years</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 2 - Every 3 years</td>
<td>120</td>
<td>490</td>
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<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 3 - Every 3 years</td>
<td>78</td>
<td>94</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Patient Safety - Every Two Years</td>
<td>448</td>
<td>887</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Resuscitation Training - Every Year</td>
<td>285</td>
<td>478</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Resuscitation Training Every 3 Years</td>
<td>97</td>
<td>420</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Venous Thromboembolism</td>
<td>25</td>
<td>73</td>
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<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 2 - 3 Years</td>
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<td>1045</td>
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<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>235</td>
<td>1021</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 3 - 3 Years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2714</td>
<td>8577</td>
<td>11291</td>
<td>76%</td>
</tr>
<tr>
<td>Name of course</td>
<td>Staff trained (YTD)</td>
<td>Eligible staff (YTD)</td>
<td>Completion rate</td>
<td>Trust Target</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>1501</td>
<td>1597</td>
<td>94%</td>
<td>95%</td>
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<tr>
<td>Safeguarding adults (Level 1)</td>
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<td>1597</td>
<td>93%</td>
<td>95%</td>
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<tr>
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<td>85%</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
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<td>1256</td>
<td>81%</td>
<td>85%</td>
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<tr>
<td>Safeguarding children (Level 3 additional)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
</tr>
</tbody>
</table>

For staff in medical care services the compliance target was not met, however it was very close to the target in four out of the five training modules.

(Source: Additional Data Request ALL2)

Cleanliness, infection control and hygiene

The service controlled infection risk well. All ward areas we visited appeared visibly clean and all equipment we inspected was clean.

We saw that personal protective equipment such as gloves and aprons, were available for staff and used appropriately. Handwashing facilities and alcohol gel were available in each bay and side-room. We saw staff washing their hands and they adhered to the trust policy of bare below the elbows. However, we noticed that not all staff decontaminated their hands when entering and leaving a ward.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door. There were different signs for respiratory risk and general risk so staff knew if they needed to wear a facemask.

Infection control audits (FLO audits) were carried out monthly and the results were shared with the ward manager and nursing staff.

We saw appropriate segregation of clinical waste and disposal of sharps. Sharps bins were correctly assembled, dated and signed with a temporary closure in place.

Staff were required to attend infection control training as part of their mandatory training. Compliance for the Division of Medicine was 83% the end of June 2018. In addition, relevant staff received aseptic non-touch technique training (ANTT).

The division had identified an increase in the number of cases of Clostridium difficile. There had been 14 cases in the division since 1 April 2018, 9 of which were trust attributable and 7 occurred at Pinderfields. This was above the target trajectory. The trust had formed an action plan to reduce the number of cases, which was being led by the infection control team.

Environment and equipment

All wards we visited were tidy, well organised and visibly clean. Cleaning was in progress in the areas we visited with safety signage displayed.

At the last inspection we found extra capacity beds in ward areas which were cramped and patients did not have correct furniture or a call bell. At this inspection we found no extra capacity beds.
Wards had a number of bedded bays and side rooms. All bays were single sex and had ensuite facilities as did side rooms.

The regional spinal injury rehabilitation unit was spacious and well equipped. It had a conditioning room, a large gym and an outdoor courtyard. All patients had access to televisions, which were funded by charity and free of charge to patients.

There was a family room with facilities for relatives to make themselves a drink on the acute frailty assessment unit.

We checked 30 pieces of equipment which included hoists, blood pressure monitors and chair scales. We found they were in good working order and had been safety tested and checked according to manufacturer’s recommendations. The exception to this was the defibrillators and suction machines on the resuscitation trolleys which were due for maintenance checking in May and June 2018. We queried this with the trust who informed us that there was a 60 day period of grace built into the review dates which meant the equipment was not yet overdue and was scheduled for checking in July.

Oxygen cylinders we checked were maintained and secured.

Resuscitation trollies had been checked daily by staff on all wards we visited. The trollies were unlocked for quick access; staff told us this had been risk assessed and was trust policy.

Some equipment had been labelled with ‘I am clean’ stickers, with the date the equipment was last cleaned. However, the use of these was inconsistent and some of the stickers were dated in April and May 2018.

Equipment for the management and prevention of pressure ulcers was available such as specialist mattresses and cushions.

The decontamination facilities for endoscopy equipment were out of use as an issue with the water supply had been identified. Work was ongoing to rectify this and a mobile decontamination unit was in use as an interim measure.

The stroke unit had received new monitors for hyper acute stroke patients and medical and nursing staff were receiving training on the ward regarding the use of the new equipment.

**Assessing and responding to patient risk**

Measures were in place to ensure that staff assessed and responded to patient risk.

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. Nursing staff recorded patient observations and entered them onto a hand held electronic clinical record system, which calculated the patients NEWS. The electronic system alerted nursing staff if the patient’s NEWS changed and if action needed to be taken.

Compliance with staff carrying out patient observations on time was measured and reported on the ward dashboard. The results were colour rated depending on the score. Results for the wards at Pinderfields for October 2017 to June 2018 varied with the majority showing a rating of amber (75% - 85%) and green (above 85%). The exceptions to this were Gate 43, Gate 44 and Gate 45A which were shown as red (below 75%).

The trust audited the effective use of NEWS and escalation of deteriorating patients. We saw the report for September 2017 and this had an appropriate action plan for areas which required improvement.
Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk.

Staff updated risk assessments for falls, pressure damage and nutrition weekly. The Trust had introduced a process were staff were encouraged to reassess all patients for nutritional risk on Monday, pressure risk on Wednesday and falls risk on Friday.

The division recognised that patient falls was a major risk to patient safety and this was included on the risk register. A corporate falls work stream was in place to reduce the number of falls with harm. The work stream was led by a dedicated falls lead for the trust. All patients were risk assessed for falls and for those found to be at risk, a number of measures were put in place. These included the provision of red anti-slip socks, correct walking aids and the use of sensor mats. Patient at risk were cohorted into high observation areas. Safety support staff were available to provide one to one support to patients identified with a high risk of falling. Information was shared with staff at twice daily safety huddles to alert them to which patients were at high risk of falling. The acute assessment unit was trialling a green wrist band for patients at risk of falls. We saw that some wards were trying to reduce the number of falls by using a system 'tagging' where a member of staff was allocated to a bay of patients who were at a high risk of falls. The member of staff needed to call for another member of staff to replace them before leaving the bay for any reason to ensure patients identified as being at high risk of falls were not left unsupervised at any time. All falls were investigated and taken to a panel to identify whether they were avoidable or not and what learning could be shared. Staff had asked that the incident reporting system be looked at to enable the disaggregation of falls and collisions as they were currently reported under the same category and this may mean the number of falls was interpreted as being higher than the actual number.

Wards displayed how many days they had been free from falls and were rewarded with a bronze, silver or gold certificate if they achieved a specific number of days free from a patient fall.

We observed a patient collapse on the stroke ward. Staff carefully supported the patient as she fell to the ground. The doctor and nurse assessed any harm to the patient and carried out appropriate observations.

A new pressure ulcer risk assessment tool and care plan had been implemented. Measures were put in place for patients deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments. Staff referred patients to the tissue viability specialist nurse if they needed advice on how to manage a high risk patient. Work was ongoing to reduce patients experiencing pressure damage. The trust was rolling out ‘react to red’ face to face training for all health care assistants as part of pressure damage improvement work. The division held monthly pressure ulcer quality meetings which included reviews of recent investigation reports and lessons learnt.

Patients should be screened within six hours of admission for risk of venous thromboembolism (VTE). This was audited monthly by the division and the results were included in the divisional dashboard. The year to date results in the dashboard were 91%. The unit manager and senior sister of the acute assessment unit were driving to improve this figure and had reviewed the clerking in documentation to make this more prominent.

The trust had appointed a clinical nurse specialist in September 2017 to raise awareness of sepsis, improve identification in clinical areas and track performance. A sepsis screening tool was included in the admissions pack in all patient records. There was a section for nursing staff to complete with a clear escalation process for staff to follow. Not all wards had a specific sepsis trolleys, but staff told us they felt equipped to deal with sepsis quickly on the ward. Think delirium posters and signs of sepsis posters were displayed in clinical areas to raise staff awareness.

Gate 32 (diabetes/endocrinology ward) had started to pilot a ‘CPR for feet’ document which required nursing staff to check the feet of all in-patients with diabetes within 24 hours of admission. The document required staff to check patient’s feet for any signs of ulceration or infection and put
protective measures in place. It included advice on what to refer to the inpatient podiatry service and how to refer to the vascular team at Leeds for limb threatening conditions.

There was an assessment tool that staff could use to identify and assess patients with possible mental health conditions. The assessment tool recommended action staff should take depending on patient’s initial mental health assessment and associated risk. However, the tool was not used consistently and in one record staff had recorded that the individual was not at risk when the completed assessment tool indicated otherwise.

When ward staff referred patients to the psychiatric liaison service, they responded in a timely manner. However, in the records we looked at we did not see clear formulations of risk or risk management plans that would provide guidance for ward staff.

In response to a small number of patients needing to return to the unit after being transferred out to Pontefract for rehabilitation, the stroke unit manager told us how they had changed the criteria and process for transferring stroke rehabilitation patients. For example, patients with nasogastric tubes were fasted before transfer to reduce the risk of aspiration occurring. Patients needed to be clinically stable and be suitable for rehabilitation with clear goals before transfer. Those with vulnerable chest conditions remained at Pinderfields for rehabilitation, to prevent having to re-transfer if patients had an exacerbation of their chest condition.

**Nurse staffing**

We had concerns about the level of registered nurse staffing on the wards. Fill rates for registered nurse staffing in the day were low on most wards.

Overall unfilled shifts for qualified nurses in the Division of Medicine from April 2017 to March 2018 ranged from approximately 12% to 18% (see graph below).

![Bank and Agency Nursing staff use (April 2018 - March 2018)](Image)

(Source: Trust Routine Provider Information Request)

The trust used the safer nursing care tool to calculate ward staffing levels and establishments. This takes into account the acuity and dependency of patients on the ward. However, staff could not tell us if this was used on a daily basis when staffing levels were being reviewed.

All wards we visited had registered nurse vacancies. Ward managers that we spoke with told us that nurse staffing was their main concern and they were often short of one registered nurse during the day. Ward managers were allocated 15 hours per week management time but told us they rarely had this as they were often needed to support staff with patient care on the wards. If staffing levels felt unsafe, ward managers raised a red flag on the e-roster system and could call the staffing bleep holder for assistance. At night staff were able to contact the on-site night matron if they needed to escalate a staffing issue.
The average fill rate on the respiratory wards (Gate 45A and 45B) for registered nursing staff in the day ranged between 55.7% and 70.6% for the months of May and June 2018.

The acute assessment unit had 58 beds and a four bedded GP unit. The planned staffing levels were eight registered nurses, two assistant practitioners and six health care assistants. In addition to this, there was a band 6 nurse co-ordinator who was not in the nursing numbers and a senior sister (Band 7). The unit was divided into coloured zones and staff were divided into eight teams of one registered nurse and one assistant per team. At the time of the inspection there were 11 registered nurse vacancies on the unit, six of these vacancies had been offered to newly qualified nurses who were due to commence in September 2018. The unit was short of one registered nurse on the day we visited.

Nurse staffing levels on the regional spinal injury rehabilitation unit were poor. They were often short of two registered nurses on the early shift and one on the late shift. Due to low staffing levels and the fact that staff lacked education and competencies in tracheostomy care, the unit was not able to safely care for patients with tracheostomies. A decision had been made for these patients to be cared for in the intensive care unit or the high dependency unit until staffing levels improved.

However, on the stroke ward (Gate A2), actual staffing levels met planned at the time of inspection, and fill rates for the previous month had all been above 90%. Planned staffing was six registered nurses and five health care assistants (HCAs) for daytime and five registered nurses and three HCA at night (for 38 beds). The ward manager told us that staffing levels were regularly reviewed but felt that the Hyper Acute Stroke Unit (HASU) element of the ward needed to be reviewed separately from the rest of the ward as this area required a higher nurse to patient ratio. Vacant shifts were covered by agency staff and it was easier to fill night shifts.

The respiratory Acute Care Unit (ACU) had 11 beds open with a mix of level 1 and level 2 patients. Planned staffing was four registered nurses (which included the shift coordinator) and two health care assistants (HCA) for daytime and four registered nurses and one HCA at night. Staff told us that planned staffing levels were maintained on most shifts. Five new registered nurses had been recently recruited to start in September 2018, this would enable the unit to open the remaining beds and give capacity to care for 14 patients.

To ensure minimum staffing levels were achieved, staff were asked to move to different wards within both Pinderfields Hospital and Pontefract Hospital. Vacant shifts were offered out to bank staff and agency. An initiative of allocate on arrival had been introduced so nursing staff would be overbooked then allocated to areas most in need.

A nurse staffing briefing for medical wards was held on weekdays at 2.30pm. This was attended by a representative from each ward. Nurse staffing levels across all medical wards were discussed for all three sites to identify areas of pressure and provide solutions for the next 24 hours. Plans for the weekend were also discussed. We observed a staff briefing during the inspection and this included contingency ahead of the weekend due to the England football match. It was anticipated that bank and agency staff might cancel at short notice leaving staffing levels vulnerable. Plans were put in place for nursing staff in the surgery division to help on medical wards and for the REACT team to help. Wards with patients needing enhanced support and those on DoLS were also discussed.

The Division of Medicine acknowledged the risk of nurse staffing numbers and this was on the divisional risk register. The division was participating in the trust active recruitment programme and were also concentrating their efforts to improve staff retention.

To reduce the risk to patient care, the division had over recruited to health care assistants (HCA) and additional HCAs were allocated to understaffed wards. They had developed new roles within the unqualified nursing staff to bridge gaps in staffing. This included safety support staff (Band 1) who provided enhanced care to patients, advanced care support workers (Band 3) who could do bloods/cannulas and assistant practitioners (Band 4). In addition to this, wards had discharge co-ordinators to assist the nursing staff with tasks related to discharging patients home.
The division had carried out a full review of skill mix in all inpatient areas and was carrying out a
review of all vacant posts. The next stage was to commence the implementation of a skills
framework for the workforce.

Nurse handover was twice daily at 7am and 7pm. We observed an evening nurse handover and
found that an effective, comprehensive review and update of each patient and their needs was
provided to the staff that had come on duty. Staff held a paper version of an electronic handover
sheet, which was updated daily to ensure accurate information about each patient, was included.

The trust has reported their staffing numbers below as at March 2018 for medicine:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Actual WTE Staff in month as at March 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mid Yorkshire NHS Trust</td>
<td>708.5</td>
<td>582.9</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 14.3% in medicine, compared
to the 9% trust target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.4% in medicine, compared
to the 12% trust target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 5.3% in medicine,
compared to the 4.8% trust target. (AAU 4.3%)

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
**Bank and agency staff usage**

The below table shows total shifts filled by bank/agency qualified nursing staff and shifts left unfilled from April 2017 to March 2018 in medicine at The Mid Yorkshire Hospital NHS Trust by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>2,785</td>
<td>5,054</td>
<td>12,522</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>633</td>
<td>2,345</td>
<td>3,159</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>117</td>
<td>244</td>
<td>568</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,535</strong></td>
<td><strong>7,643</strong></td>
<td><strong>16,249</strong></td>
</tr>
</tbody>
</table>

The trust has identified five medical wards that have among the highest bank/agency usage as a result of high vacancies. These are Gate 12 acute assessment unit (12.2% vacancy rate), Gate 43 elderly care (4.6% vacancy rate), Gate A2 stroke and neurology (2.1% vacancy rate) at Pinderfields Hospital, Ward 6 at Dewsbury and District Hospital (4.2% vacancy rate) and the Medical and Stroke Rehabilitation Unit at Pontefract Hospital (9.0% vacancy rate).

The trust states that they have a comprehensive recruitment programme, which includes graduate, return to practice and return to the NHS and international recruitment. The trust is focusing on retention of staff and has deployed several initiatives which include career cafes and internal transfer scheme, platinum retention plan, and graduate nurse programme.

Six monthly staffing reviews ensure the workforce meets the demands of the service and allows the wards to consider new workforce models including assistant practitioners, nursing associates and pharmacy technicians.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

Medical handovers occurred twice daily at 9am and 9pm. We observed a medical handover on the acute assessment ward (AAU) and the acute frailty assessment unit. Both handovers were thorough and efficient with all information clearly communicated and recorded on an electronic handover sheet.

Four consultants carried out round wards every morning on AAU and two respiratory consultants did ward rounds morning and evening. There was a registrar on duty 24 hours a day taking referrals who was supported by junior doctors. Between the hours of 9pm to 9am, there was a consultant on call.

The acute frailty assessment unit (AFAU) received direct patient admissions and had registrar cover 24 hours a day. There were also three care of the elderly consultants who carried out ward rounds in the morning and mid-afternoon to review any new admissions.

The coronary care unit (CCU) was situated with the cardiology ward (Gate 31A). Two cardiology consultants covered the ward, one consultant covered patients on the ward and the second covered patients in the CCU. A consultant was present seven days a week. Out of hours there was an on-call cardiologist.

One consultant told us there was a shortage of junior doctor cover and this was particularly an issue at night. Nursing staff and junior doctors told us that this shortage often resulted in delayed
discharges as the junior doctors needed to prioritise more urgent work, discharge letters and prescriptions were a lower priority.

Junior doctors we spoke with told us there were always gaps in the rotas. These were sometimes filled with locums but they were often moved off their base ward to cover other areas. They sometimes had to carry and respond to two bleeps.

Despite the issues with unfilled rotas the junior doctors said they were well supported by the registrars and consultants, and still had the opportunity to attend their training.

Staff on the medical step down unit (Gate A1) told us that they sometimes had difficulty getting medical staff to attend if a patient deteriorated. They said it could take a few phone calls to find someone and this could cause delays for the patient to be attended to.

Out of hours medical cover for the hospital was three registrars (one based on AAU, one based on CCU and one based on the AFAU). They were supported by four junior doctors and a consultant on call. There was also a junior doctor on a twilight shift until midnight. The number of registrars had been increased from two to three since our last inspection. The medical team could escalate to the critical care outreach team if necessary. Doctors we spoke with told us that it was very busy at night and they often did not get a break but it did not feel unsafe.

The division were aware of the difficulty to recruit medical staff into some specialities and had appointed six physicians associates and a number of advanced nurse practitioners. We also met one member of staff in a new role of doctor’s assistant. A medical workforce review was underway.

The trust supplied information about their fill rates for junior doctors from 12 March to 30 June 2018. This was for all three hospital sites;

<table>
<thead>
<tr>
<th></th>
<th>Filled</th>
<th>Unfilled</th>
<th>Filled %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-18</td>
<td>506</td>
<td>44</td>
<td>92%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>645</td>
<td>68</td>
<td>90%</td>
</tr>
<tr>
<td>May-18</td>
<td>656</td>
<td>108</td>
<td>86%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>566</td>
<td>92</td>
<td>86%</td>
</tr>
</tbody>
</table>

The trust has reported their staffing numbers below as at March 2018 for medicine:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at March 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mid Yorkshire NHS Trust</td>
<td>276.7</td>
<td>257.4</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 12.6% in medicine, compared to the 9% trust target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 5.9% in medicine, compared to the 12% trust target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 1.1% in medicine, compared to the 4.8% trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The below table shows total shifts filled by bank/locum medical staff from April 2017 to March 2018 in medicine at The Mid Yorkshire Hospital NHS Trust:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by locum staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td>4,537</td>
<td>16,353</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the 210 whole time equivalent staff working in medicine at The Mid Yorkshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics - January 2018)

Records

Staff kept appropriate records of patients’ care and treatment. Patient records were a mixture of paper based and electronic records. Staff completed nutritional risk assessments, pain assessment and dementia screening on the electronic records system. Other assessments such as patient handling, falls and pressure damage risk assessments were recorded in paper format.
Care plans were added to patient records when indicated. For example, there was a catheter care plan, a dementia pathway and a nutrition and hydration care plan. Some paper records were kept at the patient’s bedside. These included intentional rounding charts, food and fluid charts and fluid balance charts.

On most wards paper records were stored in unlocked trolleys; however, these were stored in areas supervised by staff near to the nurse’s station. On the acute assessment unit, medical and nursing notes were stored together in folders kept at nurses’ station. They were not kept in a locked area; however, a member of staff was always present. We observed on three occasions patients’ confidential notes left unattended on the ward.

We looked at a sample of 34 patient records which included paper and electronic records. These were completed to a good standard. We found that care plans and risk assessments were completed appropriately.

The electronic patient system was used to flag specific patient information, for example, a flag was used for patients living with dementia or those patients with a learning disability. A ‘VIP’ sticker was placed on medical notes of patients with a learning disability and a ‘forget me not’ sticker for patients with dementia.

**Medicines**

Medicines were stored securely with access restricted to authorised staff members. Medicines rooms were tidy and well organised. A centrally monitored system was in place to ensure that medicines were stored at the correct temperature.

Medicines and equipment required in emergencies were appropriately stored and checked daily to ensure they were fit for use.

Controlled drugs were ordered appropriately. Record checks for stock medicines were completed each day and on all wards we visited these were correct. However, on the acute assessment ward, we found some controlled drugs which had been kept in storage for a month after the patient had passed away. We mentioned this to the ward manager who arranged with the pharmacist for these to be collected and disposed of straight away.

The trust had a self-administration policy and staff were able to describe how they would use this policy. However, we found two patients were self–administering medicines on the respiratory ward without having a risk assessment in place in line with policy.

An audit of oxygen prescribing was in place and results had improved. A respiratory specialist pharmacist visited the respiratory wards (Gate 45A and B) and the acute respiratory unit. We looked at six prescription charts for patients on oxygen and out of these one did not have oxygen prescribed on their chart.

When people were prescribed antibiotics there was clear information on indication and review dates.

When medicines were administered via a syringe driver we found that staff were not completing four hourly checks of the syringe drivers and the infusion sites in line with trust policy.

The paper copies of Patient Group Directions (PGD) on the oncology ward, which allowed nurses to administer certain medicines without a prescription, were out of date. Individual nurses who could administer the medicine under the PGD were not listed and had not signed the individual authorisation form attached to the end of each PGD as detailed in the Trust Policy.

Nursing staff wore a red apron to indicate to others they were carrying out a medication round. This was to minimise interruptions and reduce drug errors. However, these were not used consistently on all wards we visited.
There was good pharmacy support for the cardiac ward and the coronary care unit. A pharmacist attended morning ward rounds and also held regular clinics on Tuesday mornings.

Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust governance arrangements. Staff we spoke with knew how to report incidents involving medicines. Significant incidents were discussed and appropriate actions taken in response to concerns.

**Incidents**

Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they received feedback from incidents. Feedback and learning from incidents was cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

The patient safety panel reviewed lessons learnt from serious incident investigations, pressure ulcers and falls. Once identified these were shared with staff via a two weekly patient safety bulletin.

We observed a falls briefing delivered to a group of therapists which contained information about recent incidents and learning from the investigations. Staff were informed about some changes to the paperwork for patient risk assessments and to the IT systems staff used. The briefing was concise and was followed by a practical moving and handling update.

Information about incidents was also shared at the safety brief which occurred at nurse handover at 7am and 7pm.

At the inspection in 2017 the division had a backlog of 300 unresolved incidents. The leadership team confirmed that this had now been resolved.

Staff we spoke to knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients. Ward managers were aware of the DoC and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty. DoC was incorporated into the incident reporting system.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for medicine.

(Source: NHS Improvement - STEIS (May 2017 – April 2018))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from May 2017 to April 2018.
Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 18 (64% of total incidents).
- Pressure ulcer meeting SI criteria with six (21% of total incidents).
- All other categories with one (4% of total incidents).
- Treatment delay meeting SI criteria with one (4% of total incidents).
- VTE meeting SI criteria with one (4% of total incidents).
- Medication incident meeting SI criteria with one (4% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 83 new pressure ulcers, 51 falls with harm and 33 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.
The Mid Yorkshire Hospitals NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: Safety thermometer)

Harm free care information was displayed on ward notice boards. Gate 43 showed that from December 2017 to May 2018 they had four months with 100% harm free care, one month with 98% and one with 93% harm free care.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We reviewed a random selection of five policies including the falls policy, the fluid balance management policy for adult patients and the safe nurse staffing policy. All were within their review date.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible
evidence and in line with national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

There was a process in place to ensure that clinical practice was in line with the service NICE guidance. Clinical leads carried out a gap analysis and identified actions required to address any gaps.

The care of the elderly team had designed a new patient assessment document which followed the acute care of the elderly pathway and was based on the Royal College of Physicians guidance. The document was going through the trust governance processes prior to rolling out.

The service regularly reviewed the effectiveness of care and treatment through local and national audit. We saw that following audit, there were recommendations and actions for improvement, which included allocation of lead responsibility, completion dates and evidence to demonstrate that actions had been completed. We saw in the notes of the divisional governance meetings that there were some backlogs in provision of evidence for action plans and these were being chased up.

**Nutrition and hydration**

There was a divisional nutritional and hydration group which focused on improvements in this area. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Patients were screened on admission and then weekly using the Malnutrition Universal Screening Tool (MUST). Food and fluid charts were completed for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic service.

We saw that red jugs and red trays were in use to indicate to staff which patients needed assistance with their meals. Mealtimes were protected. We heard one nurse asking medical staff to stop seeing patients so they could eat their meals. Relatives were encouraged to stay and help with meal times if they wished. We saw patients being supported to eat and drink and that drinks were readily available and were in easy reach of patients.

Wards we visited had a white board in the pantry which identified if patients had specific dietary needs such as a soft diet, pureed or thickened fluids. It also stated if a patient was nil by mouth.

Food menus were on a 14 day cycle to provide variety for patients. Ethnic meals could be provided and the menus were available in six different languages on request.

Patients we spoke with were happy with the food and drink they were given.

We looked at three patients with naso-gastric tubes food and fluid charts on the stroke unit and found that fluid input could be recorded on more than one chart. For example, oral intake could be recorded on a food and fluid chart while enteral and parenteral fluids and urine output were recorded on a fluid balance chart or an enteral nutrition chart. This meant that it was more difficult for nurses to complete 24-hour fluid balance accurately as information was recorded in a number of places. We found that 24-hour fluid balance was not always completed. When we discussed fluid balance recording with ward managers, they recognised this was an area for improvement and it was felt that poor recording was compounded by the overuse of fluid balance charts with patients when there was no clinical need for this and a food and fluid diary would be more appropriate.
Pain relief

The service managed pain relief well. Patients we spoke with had no concerns about how their pain was managed and staff checked with patients that pain relief administered had been effective. Staff used a pain-scoring tool, from one to 10, to assess a patient’s level of pain. The pain score was recorded on the electronic clinical record system. Pain relief was provided as prescribed and there were systems in place to ensure that additional pain relief could be accessed through medical staff, if required.

A consultant anaesthetist and the pain specialist nurse visited the spinal injuries rehabilitation unit twice a week to carry out a pain round. We looked at the records of five patients on the unit and found that all patients had pain scores completed each time their observations had been carried out.

Pain management was audited as part of the quarterly matron health check. This was a peer audit supported by the clinical audit team and formed part of the nursing quality governance framework. The results for the division of medicine for the previous 12 months are included below;

<table>
<thead>
<tr>
<th>Pain Management</th>
<th>Q2 17/18</th>
<th>Q3 17/18</th>
<th>Q1 18/19</th>
<th>Q2 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Pain status assessment on VitalPac</td>
<td>99%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>B. Pain care plan in place where indicated (n/a if not required)</td>
<td>55%</td>
<td>41%</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>C. Evidence of pain being reassessed on regular basis</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Patient outcomes

The service participated in relevant quality improvement initiatives, including local and national clinical audits. Local audits included infection control and hand hygiene audits, falls, pressure ulcer, fluid balance and nutrition audits which were carried out monthly or bi-monthly.

The trust had been identified as an outlier for acute and unspecified renal failure, fluid and electrolyte disorders, septicaemia (not in labour) and acute cerebrovascular disease. Action plans were in place to improve these areas.

The divisional leaders told us that their Hospital Standard Mortality Ration (HSMR) had improved since the acute hospital reconfiguration.

The trust had mixed results from national audits. There were some positive outcomes in the Sentinel Stroke National Audit programme with the trust achieving grade B in latest audit which was an improvement from the previous audit. In the Heart Failure Audit results were better than the England and Wales average in two metrics, similar in one and slightly worse in fourth. For discharge scores Pinderfields Hospital scored better than England and Wales average in all nine measures. There were mixed results in the National Diabetes Inpatient Audit and the results of the National Audit of Inpatient Falls were poor. The falls work stream discussed the results of the national inpatient falls audit and had put action plans in place to improve results.

The endoscopy service had not met the requirements of the Joint Advisory Group on Endoscopy (JAG) and had lost accreditation. Staff told us there was an action plan to work towards regaining accreditation and the division had commissioned a senior consultant to move the action plan forward.

Relative risk of readmission
Trust level

From January 2017 to December 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Pinderfields Hospital

From January 2017 to December 2017, patients at Pinderfields Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Pinderfields Hospital

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Non-Elective Admissions - Pinderfields Hospital**

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar to expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: HES - Readmissions (January 2017 – December 2017))

**Sentinel Stroke National Audit Programme (SSNAP)**

The Mid Yorkshire NHS Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, April 2017 to July 2017, which was an improvement from the previous audit, December 2016 to March 2017, where the hospital achieved grade C.

The combined total key indicator level in the overall scores has seen an improvement in performance from grade C to grade B in the latest audit.

**Pinderfields Hospital**

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
</tbody>
</table>
### Patient centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C↑</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>A↑↑</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
<td>E↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D</td>
<td>E↓</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
<td>D↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
</tbody>
</table>

**Legend:**

- Best: A
- Good: B
- Moderate: C
- Poor: D
- Worst: E
- N/A: No assessment

### Team centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C↑</td>
<td>B↑</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C</td>
<td>D↓</td>
<td>B↑↑</td>
<td>B</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D</td>
<td>E↓</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
<td>D↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

**Legend:**

- Best: A
- Good: B
- Moderate: C
- Poor: D
- Worst: E
- N/A: No assessment
- Domain 3: Thrombolysis has seen an improvement from grade C to grade B in the latest audit for both patient and team centred performance.

- Domain 6: Physiotherapy has seen a decline in performance from grade B to grade C in the latest audit for both patient and team centred performance.

- Domain 7: Speech and language therapy has seen a decline in performance from grade D to grade E in the latest audit for patient centred performance.

- Domain 8: Multi-disciplinary team working has seen an improvement in performance from grade E to grade D for both patient and team centred performance.

(Source: Royal College of Physicians London, SSNAP audit)

Heart Failure Audit

In-hospital Care Scores

Results for Pinderfields Hospital in the 2016 Heart Failure Audit were better than the England and Wales average for one metric and similar for two metrics. The remaining metric (input from a consultant cardiologist) was slightly worse than the standard.

Discharge Scores

Results for Pinderfields Hospital for the standards relating to discharge were better than the England and Wales average for all nine measures.
National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 106 in-patients with diabetes at Pinderfields Hospital. 81.6% of patients at Pinderfields Hospital with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 2.

Pinderfields Hospital:

- 13.5% of patients had been on an insulin infusion in the last seven days, which places this site in quartile 4, compared with quartile 3 in the 2016 audit.

- 26.3% of patients with diabetes experienced at least one prescription error, which places this site in quartile 4 and is the same quartile as in the 2016 audit.

- Of the patients on insulin, 22.5% experienced one or more insulin (prescription or glucose management) error, which places this site in quartile 4, compared with quartile 3 in the 2016 audit.

(SOURCE: NICOR - Heart Failure Audit (April 2015 – March 2016))
• 10.6% of patients with diabetes experienced one or more severe hypoglycaemic episode (<3.0mmol/L), which places this site in quartile 4, compared with quartile 3 in the 2016 audit.

• 50.4% of patients with diabetes reported that the timing of their meals was always or almost always suitable, which places this site in quartile 1, compared with quartile 2 in the 2016 audit.

• 30.9% of patients with diabetes reported that the choice of their meals was always or almost always suitable, which places this site in quartile 1, compared with quartile 3 in the 2016 audit.

• 69.5% of patients with diabetes reported that all or most of the staff caring for them were aware that they had diabetes, which places this site in quartile 1, compared with quartile 2 in the 2016 audit.

• 65.1% of patients with diabetes reported that staff were definitely, or to some extent, able to answer their questions in a way that they understood, which places this site in quartile 1 and is the same quartile as in the 2016 audit.

(Source: National Diabetes Inpatient Audit 2017)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 39.7% of nSTEMI patients at Pinderfields Hospital were admitted to a cardiac unit or ward compared to the England average of 55.8%.

97.6% of nSTEMI patients at Pinderfields Hospital were seen by a cardiologist or member of the team compared to an England average of 96.2%.

The proportion of nSTEMI patients who were referred for or had angiography was 79.2% at Pinderfields Hospital compared to an England average of 83.6%.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>282</td>
<td>282</td>
<td>361</td>
</tr>
<tr>
<td></td>
<td>97.6%</td>
<td>39.7%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>175</td>
<td>175</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>94.3%</td>
<td>25.1%</td>
<td>67.5%</td>
</tr>
<tr>
<td>England: overall</td>
<td>47,039</td>
<td>47,039</td>
<td>39,082</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 87.9%, which did not meet the audit minimum standard of 90%. The 2016 figure was 1.8%.
The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.6%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 73.5%. This is better than expected and shows good practice. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 76.3%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The one year relative survival rate for the trust in 2016 was 35.4%. This is within the expected range. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit 2017)

National Audit of Inpatient Falls

The Mid Yorkshire Trust participated in the 2017 National Audit of Inpatient Falls and the crude proportion of patients who had a vision assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 30%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 21%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 78%. This did not meet the national aspirational standard of 100%.

(Source: National Audit of Inpatient Falls 2017)

Competent staff

Appraisal rates

Information provided by the trust showed that the overall appraisal rates for staff working in medical care services on 30 June 2018 were 85% which met the trust target of 85%.

<table>
<thead>
<tr>
<th>Appraisal compliance</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand total</th>
<th>% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisals</td>
<td>209</td>
<td>1232</td>
<td>1441</td>
<td>85%</td>
</tr>
</tbody>
</table>

(Source: Additional Data Request ALL2)

Staff we spoke to had completed their annual appraisal with their line manager and said they found it useful. Ward managers were aware of the ward compliance with appraisals and had plans in place to meet with those staff whose appraisals were outstanding. At the time of the inspection compliance rates were high. For example; 92% for the acute assessment unit, 99% for the acute frailty assessment unit, 95% for the Cardiology Wards (Gate 31A and B) and 89.5% for the spinal rehabilitation unit (Gate 4).

Newly qualified nurses were given a preceptorship programme and were supported by a mentor. Nurses we spoke with had received a full day induction and two weeks of training. They had received additional training for taking bloods/cannulation and intravenous drugs.
Staff were encouraged to develop and were able to attend additional training if it fit with their role. The learning disability lead was studying for a master’s degree supported by the trust.

Junior doctors told us they had a good induction when they joined the trust. Those we spoke with were able to attend their training days although they were aware this sometimes left medical staffing short on the wards.

Therapy staff told us they had bespoke in service training. They also provide extra training to the wider team. For example they had provided training to health care assistants taking part in the pyjamas paralysis challenge, to encourage patients to get up and dressed.

Staff on the respiratory acute care unit had received additional training to enable them to carry out blood gases for respiratory patients and registered nurses had competency based in the care of patients receiving Non-invasive ventilation (NIV).

Staff on wards supported student nurses on clinical placements. Students we spoke with said they felt well supported.

Patients who presented with higher risks of harm to themselves or others were often observed by unregistered staff or security staff. Mental health training was not mandatory for nursing staff although some ad-hoc training was available. Security staff received training in safeguarding and Mental Capacity Act level 1.

**Multidisciplinary working**

Staff with specialist skills and knowledge worked well together to benefit patients. Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

Staff spoke highly of the early support and discharge team and their role. Staff valued the part each member of the ward team played in caring for patients and the support given to the whole team and effective running of the ward.

We saw good examples of MDT working. Clinical and non-clinical staff attended daily twice daily safety huddles to share information about patient risk. Wards held multidisciplinary board rounds Monday to Friday. We observed a board round on Gate 43, which was attended by the consultant, junior doctor, physiotherapist, charge nurse, discharge liaison sister, advanced support worker and social care worker. All patients on the ward were discussed in detail including safety risks, social situation and discharge planning. Actions were identified and noted which required completion before the patient could be safely discharged home.

Referral pathways were in place for referral to the speech and language therapist, podiatrist and dietitian. Pharmacist and pharmacy technicians supported wards.

Specialist nurses were available to offer support, advice and training to staff in a number of specialist areas. These included tissue viability, dementia, diabetes, falls and learning disability.

The Rapid Elderly Acute Care Team (REACT) were based on the acute frailty assessment unit and were a multidisciplinary team of medical staff, specialist nurses, healthcare assistants, therapists and social care workers. Staff said they worked well together as a team to achieve the best outcome for patients.

We observed multidisciplinary interventions on the stroke unit and saw evidence of multidisciplinary plans of care and evaluation of patient goals. There had been a recent investment in the speech and language therapy team and the stroke ward had dedicated input from this team three times a week. There was a multidisciplinary board round at 8am every morning.

Staff from the psychiatric liaison team and the medical wards valued each other’s input. They told us that the teams worked well together to meet patients’ physical and mental health needs. Staff told us the psychiatric liaison team provided good guidance to ward staff to ensure that patient’s
mental health needs and risks were addressed. However, in the records we reviewed, we did not find documented evidence of this.

Seven-day services

The endoscopy unit was open from 8am to 7pm Monday to Friday with some additional sessions provided on Saturdays. There was a 24 hour, seven days a week on call gastrointestinal (GI) bleed rota was in place and if endoscopy services were needed out of hours, this would be performed in the operating theatre.

There was a stroke nurse responder on duty 24 hours a day, seven days a week to respond to patients with a suspected stroke in the emergency department or on hospital wards. The team consisted of six band 6 nurses and one band 4 assistant. The transient ischaemic attack (TIA) clinic was managed by staff from the acute stroke ward and this was provided seven days a week.

Therapy staff in the REACT team provided a seven day service. At weekends three staff, an occupational therapist, a physiotherapist and a technical instructor worked for 8am to 4pm. During this time they reviewed patients who were medically fit for discharge and provided therapy for patients on Gate 42 who were rehabilitating following a fractured neck of femur.

Therapy team leaders told us that seven day working was gradually being rolled out in therapy teams. The stroke therapy team was not yet providing seven day services; however there was access to an on call physiotherapist for chest problems.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, 7 days a week with all adult patients. Staff had access to other specialist staff, such as psychologists.

The nearby mental health trust had an adult crisis team that operated 24 hours a day, seven days a week and acted as gatekeeper to mental health beds.

Health promotion

The learning disability lead nurse carried a supply of annual health check leaflets and gave these to patients with a learning disability and their carers to encourage them to attend.

Public health leaflets were displayed in ward areas around healthy eating, staying healthy.

Patients and relatives were given an extensive information pack which covered all aspects of stroke, including rehabilitation and social requirements.

We saw a nurse demonstrating improved inhaler technique to a patient on the respiratory ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.
The MCA allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs).

Patients were asked their consent to share information regarding their care with others involved in their care. This was recorded in the nursing records. Consent to treatment leaflets for patients were on display on some wards we visited.

All patients over 64 years of age or those with concern about memory were screened for dementia using the abbreviated mental test score (AMTS).

Staff we spoke with understood the basic principles of the MCA and DoLS. They told us that if they needed to complete a DoLS application they were able to access help from the safeguarding team.

However, we saw limited examples of mental capacity assessments or decisions made in line with the principles of the MCA. Where patients lacked capacity, recording that the decision was in the patient’s best interests was not consistent.

We saw that for a patient whom staff considered may lack capacity to make a decision relating to physical health treatment, staff had carried out a corresponding capacity assessment in relation to consent.

However, we did not see best interest decisions being considered for incapacitated patients, such as a patient with cognitive impairment who was not able to return safely to their own home.

On one ward, staff had made a standard DoLS application for one patient but had not made a corresponding urgent DoLS application. There was a letter (dated the same day as the application) addressed to the patient in the file that stated they could not leave the hospital. However, assessments had not yet been carried out and the standard application had not been authorised. This meant that the patient was deprived of their liberty without procedural safeguard because staff had not completed the form correctly. We escalated this to the ward manager.

We found a patient on DoLS on the cardiology ward and this documentation had been completed appropriately. A mental capacity assessment was in place and there was evidence of best interest discussions with relatives. We saw that a patient on the stroke unit had a DoLS in place and this was being reviewed with an MCA assessment in preparation for discharge.

This meant that while nursing staff had some understanding of the principles of the MCA and the DoLS, we could not be assured that their understanding was sufficient to always ensure their practice upheld them.

The trust had carried out an audit of the completion of consent Form 4 which was for adults who potentially lack the capacity to consent to investigation or treatment. The audit had identified some areas of good practice and areas for improvement with an action plan. The audit would be repeated in 2019 to see if improvements had been made.

Mental Capacity Act and Deprivation of Liberty training completion

Staff were required to complete training in MCA and the DoLS. Information provided by the trust on 30 June 2018 showed that the overall compliance for staff within the Division of Medicine was 99% for level 1 training, which exceeded the trust target of 95%. Compliance with level 2 training was 80% and for level 3 training it was 55%, which did not meet the trust target of 85%.

The trust informed us that the reason for the level 3 training compliance being low was that initial training took place for a large number of staff in 2015 and as staff were required to complete the training every three years, a number of staff had fallen out of compliance. However, further masterclasses were planned and the trust was looking at alternative ways to provide this specialist training.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. We spoke with 17 patients and relatives throughout the inspection. Patients and relatives told us that they had been treated kindly and that staff were polite and respectful.

All patients we spoke with were happy with the standard of care they received. They had drinks and call bells located within easy reach. Patients told us they felt safe.

Patients said ‘staff are very kind’ and ‘they are busy but still caring’.

We overheard discussions between staff and patients and these were carried out in a compassionate and supportive way. Staff gave reassurance and provided information at a pace appropriate for the patient. We observed patients’ privacy and dignity were maintained when staff delivered care.

The trust encouraged staff to undertake the nursing handover at the bedside in order to improve engagement and communication with patients. We saw signage displayed on the doors to the bedded bays to remind staff of this.

From March 2017 to February 2018, the friends and family test response rate for medicine at the trust was 24%, which was about the same as the England average of 25%. The response rate for Pinderfields Hospital was 23% (based on 4,293 responses).

A breakdown of the friends and family test performance by site and for medical wards at the trust with total responses over 100 is below. The monthly figures show recommendation percentage and not response rates.

Friends and family Test – Response rate between March 2017 and February 2018 by site and ward

Pinderfields Hospital:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Ann Perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>356</td>
<td>35%</td>
<td>100%</td>
<td>92%</td>
<td>96%</td>
<td>95%</td>
<td>100%</td>
<td>98%</td>
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<td>100%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>344</td>
<td>393</td>
<td>39%</td>
<td>100%</td>
<td>94%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
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</tr>
<tr>
<td>542</td>
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<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
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</tr>
<tr>
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<td>207</td>
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<td>331</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Highest to Lowest score

Key: 100% 50% 0%

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

(Source: NHS England Friends and Family Test)
Emotional support

Staff provided emotional support to patients to minimise their distress. We saw a member of staff being extremely caring in supporting a patient who had received some bad news about their condition.

Relatives of patients living with dementia were offered information on voluntary organisations, which could provide them with support and advice. Information about a number of different charities and voluntary organisations was displayed on notice boards in ward areas.

Quiet rooms were available for relatives if they needed to speak to staff confidentially or if they were feeling distressed and needed somewhere quiet to sit.

Weekly psychology support was provided to patients on receiving care on the regional spinal injury rehabilitation unit. A charity organisation offered financial advice to patients.

Staff in the oncology ward told us that they could refer patients who experienced anxiety and depression for psychological input. There were two routes. For people with general anxiety, staff could refer to the Macmillan hub for interventions such as counselling. They could also access complementary therapies such as reiki and mindfulness. For adjustment disorder with anxiety, staff could refer patients to a psychologist. Where appropriate, staff could also make referrals to the psychiatric liaison team.

There was 24 hours access to a psychiatric liaison team.

Spiritual and pastoral support was available to patients, relatives, carers and staff. There was a multi-faith centre on site with a chapel and a prayer room. Chaplains were available to provide services for different faiths in the chapel or at the patient’s bedside.

Understanding and involvement of patients and those close to them

Patients and relatives we spoke with told us they were kept up to date with what was happening and were involved in decisions about their care. Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions.

We saw evidence in patient records that patients and their relatives had been involved in making decisions about their care and treatment. Relatives were involved in care planning and discharge arrangements for stroke patients.

We observed the husband of a patient on the oncology unit being supported by Macmillan nurses to take a short break and have a sleep for a couple of hours so he can come back to support his wife tonight. He was given a swipe card to access a family room.

Wards displayed photos and designations of ward staff so patients and visitors understood their roles.

Is the service responsive?

Service delivery to meet the needs of local people

The division had realigned their services as part of the acute hospital reconfiguration. This involved the centralisation of acute in-patient services at Pinderfields Hospital. As part of the reconfiguration they had opened two acute frailty assessment units (one at Pinderfields and one at Dewsbury and District Hospital) which accepted direct referrals. A discharge hub had been set up at both sites which could accommodate patients 24 hours a day seven days a week. Pathways to
Dewsbury and District Hospital and Pontefract Hospital had been created, and these hospitals were now designated step down facilities.

The ambulatory care unit was staffed by a dedicated team of consultants, doctors, advanced nurse practitioners (ANPs) and healthcare assistants. The unit was led by a consultant between the hours of 9am and 8pm, then the ANPs until midnight. This enabled non-critical patients to be seen quickly and relieved pressure on the emergency department. Patients could be referred directly to the unit by their GP.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, the trust had a learning disability lead nurse and VIP champions on the wards.
Average length of stay

Trust Level

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 7.8 days, which is higher than the England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

For medical non-elective patients, the average length of stay was 6.5 days, which is similar to the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Non-Elective Average Length of Stay – Trust Level
Note: Top three specialties for specific trust based on count of activity.

Pinderfields Hospital

From February 2017 to January 2018 the average length of stay for medical elective patients at Pinderfields Hospital was 8.3 days, which is higher than the England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.

Elective Average Length of Stay - Pinderfields Hospital

Note: Top three specialties for specific site based on count of activity.

For medical non-elective patients, the average length of stay was 6.5 days, which is similar to the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Non-Elective Average Length of Stay - Pinderfields Hospital
Note: Top three specialties for specific site based on count of activity.
(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs. The trust had a full time learning disability lead nurse. All patients with a learning disability were flagged on the electronic patient administration system. The lead nurse received a daily report of all flagged patients and visited to offer support and information. Family members or care staff from supported living were encouraged to stay and support the patient in the hospital setting. VIP passports were in use for patients with a learning disability, which included sections about the patient’s health, reasonable adjustments, eating and drinking, communication needs, decision-making and support needed.

There was a specialist lead nurse for dementia and dementia champions on the wards. Patients with dementia were flagged on the system and were identified to staff at safety huddles and at board rounds. A forget-me-not scheme was in use, we saw these displayed on the board at the back of patients’ beds and in patients notes. On admission, all patients over the age of 64 were screened for dementia.

The hospital aimed to meet the principles of ‘John’s Campaign: for the right to stay with people with dementia in hospital’. There were seven family support rooms available, which were adapted for patients with dementia. The rooms were themed and decorated to look like they were home from home. Rooms had large televisions and dementia clocks with the day, date and time displayed. Each room had a pull down bed so that relatives could stay with their loved ones and toiletry packs were provided.

There was open visiting on all wards and a brightly decorated reminiscence room on Gate 43. Dementia awareness information boards were displayed on the elderly care wards and staff on one ward had put up photographs of Dad’s Army characters. We saw an “all about me” passport system was in use.

Staff could access translation services through the switchboard. They could book a face to face interpreter or a booked call in the patient’s language. They could also book a face to face British Sign Language interpreter. Therapy staff told us they were wary of using family to translate for patients whose first language was not English. Posters were displayed in over 10 different languages which gave patients information on how to get more information in their own language should they need it. We saw ‘tell us what you think’ posters and leaflets were available in several languages.

To meet the needs of patients with sensory loss, patient information was available in different formats such as braille. This could be requested via the patient advice and liaison service. The trust website had the facility to enable patients to increase the font size of the text, convert the text into different languages, read the page content aloud and download patient information leaflets as audio files.

Staff were aware of the cultural needs of patients. A member of staff on the haematology ward (Gate 21) told us that a patient of the Muslim faith had passed away on New Year’s Day. He liaised with the central administration teams to ensure all paperwork was completed and cleared to enable the patient’s body to be released within the preferred 24 hour window for burial.

The regional spinal injury rehabilitation unit had excellent support from local and national charities. Activities and day trips were regularly organised for patients who were able to attend. The physiotherapy team organised a games day every Wednesday which included table tennis, wheelchair basketball and archery.
Patients with mental health needs were referred to the psychiatric liaison service and seen by trained mental health staff. The psychiatric liaison service worked 24 hours a day, 7 days a week.

Staff on the respiratory Acute Care Unit (ACU) understood that when patients improved from level 2 to level 1 care, they needed to be aware of having male and female patients in the same area. There were standards in place for mixed sex accommodation and staff knew when to report a potential breach. Staff reported potential breaches to the site manager if they could not resolve this within the unit, actual mix sex breaches were reported as incidents. The division had no reported mix sex accommodation breaches for the year to June 2018.

**Access and flow**

At the inspection in May 2017 we were concerned about the use of extra capacity beds on medical wards. At this inspection we found no additional capacity beds on wards. The leadership team told us that all extra capacity beds had been closed at the end of April 2018. The trust had worked with the wider system to improve admission and discharge planning. This included working with local authorities and clinical commissioning groups.

At the last inspection we also identified a high number of out of hours bed moves between 10pm and 7am. At this inspection we were also concerned about the number of bed moves at night (see figures below). Staff told us that bed moves at night were not uncommon.

We visited Gate 42 at 8pm and there were two patients in the process of being transferred Pontefract Hospital. Staff on the ward were preparing to receive three patients from Gate 41. Staff said that moving patients at this time happened often.

We spoke with the relatives of two patients who told us that their relative had been moved to another hospital and the family had not been informed of the move until the following evening. One patient living with dementia had been moved to Dewsbury District Hospital and his family had not been informed about the move despite visiting their relative earlier on that day.

There were a small number of medical patients outlying on surgical wards at the time of our visit. We found these patients had been regularly reviewed by medical staff. Staff told us it was sometimes a challenge to get a medical review from a speciality consultant. Nursing staff told us that during the winter period there were more medical outliers and it could be a challenge to get a timely medical review for all patients.

The Rapid Elderly Acute Care Team (REACT) was based on the acute frailty assessment unit. The team’s role was to facilitate the timely and safe discharge of patients over 80 years of age and those aged 65 years living in care homes. The team also fast tracked discharge for patients at their end of life who wanted to die at home. The service carried out weekly audits to measure effectiveness. Audit results were reviewed by the team leader and business manager to aid service improvement. Staff told us they focused on those patients who could be discharged within 48 to 72 hours.

Thrombolysis for stroke patients was carried out in a side room in the acute stroke unit. We observed the stroke nurse respond to a patient in the emergency department and this was timely and effective. The patient was admitted, scanned and transferred to the stroke unit for thrombolysis within 45 minutes. Out of hours, the stroke service used telemedicine to link with the consultant on call.

The heart failure specialist nurses provided telephone advice and support to GPs and patients. If necessary the specialist nurses could admit patients from home directly onto the ward. They also visited the emergency department (ED) to review patients, which assisted with the flow of patients through ED. They provided ‘hot clinics’ on an ad hoc basis and this service was due to be fully commissioned from August 2018.
The endoscopy service was not able to meet demand and was at risk of breaching constitutional standards. The division had brought in an external provider to provide 55 units of activity a day. This was included on the divisional risk register. The divisional performance report showed that the division were meeting their target of less than 1% of patients waiting more than six weeks from first referral to diagnostic test.

The discharge team monitored patient discharge status across the division and focused on ‘stranded’ patients. They liaised with community colleagues and support services to assist patients who were medically fit for discharge. Discharge co-ordinators were based on medical wards to support patients’ safe discharge home. There was a discharge hub which had a lounge area with 14 chairs and a ward area with 11 beds. The ward area was open 24 hours a day and the lounge was open Monday to Friday 8am to 8pm.

From Monday to Friday there was a dedicated angioplasty nurse on the cardiac ward (Gate 31A) who prepared patients for their procedure and accompanied them to the cardiac catheter laboratory. Staff told us this made the process more efficient and prevented cancellations due to patients not being properly prepared for the procedure.

The haematology ward (Gate 21) and the oncology ward (Gate 20A) both had a 24 hour triage system so that people could be directly admitted, rather than having to present and wait in the emergency department (ED) when they were at high risk of infection. The ward manager of the haematology ward told us they visited the acute assessment unit and the ED daily to check whether there were any patients suitable for transfer to their ward or to the neighbouring oncology ward and they arranged for them to be moved as a priority.

The oncology assessment unit were in the process of setting up an acute oncology service staffed by advanced nurse practitioners (ANPs). Some of the ANPs were prescribers so this meant that patients could avoid a trip to ED. They estimated that two thirds of all calls triaged could result in patients coming directly to the ward.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average. In the latest period, March 2018, 85.6% of this group of patients were treated within 18 weeks versus the England average of 88.9%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>93%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>92.3%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>80.4%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.9%</td>
<td>82.9%</td>
</tr>
<tr>
<td>General medicine</td>
<td>61.9%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>60.0%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission

The trust stated that they unable to provide the data requested as their system does not have the functionality to differentiate between moves for clinical and non-clinical reasons.

(Source: Trust Routine Provider Information Request P51)

Patient moving wards at night

Data provided by the trust indicates there were 960 ward moves at night across 24 wards from October 2017 to March 2018.

The average number of moves per ward ranged from none to 34. There were nine bed moves at night for this period at the Pontefract Medical and Stroke Rehabilitation Unit (PMSRU), 84 at Dewsbury and District Hospital and the remaining 867 were at the Pinderfields site.

(Source: Trust Routine Provider Information Request P52)

Learning from complaints and concerns

Most staff told us that complaints were discussed with them at team meetings or individually if the complaint concerned them.

Ward managers we spoke with were aware of themes and trends from complaints. Complaints were discussed at team meetings or shared with staff in a newsletter.

The ward manager of the acute assessment unit told us they had received 15 complaints between January 2018 and June 2018. Themes identified were waiting times and staff attitude. The ward manager had spoken to staff individually and at team meetings to reflect on the complaints and suggest ways of making improvements.
The ambulatory care unit had a dedicated waiting area. Previously patients had waited in the corridor and this had been changed as a result of complaints.

**Summary of complaints**

From April 2017 to March 2018 there were 281 complaints about medical care (compared to 1,624 in 2016-2017). The trust took an average of 25 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 working days.

The most common subjects of complaint were:

- Patient care (157 complaints, 56% of total complaints for this core service)
- Admissions and discharges (excluding delayed discharge due to absence of care package) (40 complaints, 14% of total complaints for this core service)
- Staff’s values and behaviours (33 complaints, 12% of total complaints for this core service)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 59 compliments within medicine:

- Pinderfields Hospital: 28 compliments
- Dewsbury and District Hospital: 31 compliments

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

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**Is the service well-led?**

**Leadership**

The Division of Medicine was led by a clinical director, a director of operations and two assistant directors of nursing.

We saw effective ward managers. Wards were well organised, tidy and appeared calm. Staff spoke positively about their local and divisional leadership and said they were well supported.

Therapy staff spoke highly of their team leaders and managers. They said they had good role models in their therapy leaders and that they understood and helped out when under pressure.

We received good positive feedback about the chief executive, the chief operating officer and the director of nursing and quality. Staff said they were visible, approachable, listened to them and took action on what they said.

Staff gave examples of the chief executive visiting wards to ask staff directly of their opinions about planned changes to services or policies and what the implications for them might be. Staff said the chief executive replied directly to staff if they had written to him with concerns or ideas.

Ward managers said they were clear where the service was heading and this was in the right direction.

Therapy and nursing staff were able to attend a certified leadership training provided by the organisation. Nursing sisters, charge nurses and ward managers could also apply to go through the Royal College of Nursing leadership accreditation scheme. Staff attributed this investment in
their leadership development to the new chief executive and the executive team. They welcomed this investment in their development.

**Vision and strategy**

The Division of Medicine had a clear vision and strategy which was linked to those of the trust. They had recently implemented a new model of care with the acute hospital reconfiguration. Staff we spoke with were aware of this and had been involved in the consultation and planning process.

The trust vision, mission and strategic aims were displayed on notice boards around the medical wards.

We saw that some wards had developed and displayed team goals for staff and patients to see. For example, the stroke ward goals for the past five months included; reducing infection rates, implementing the gold standard framework (for patients at the end of life), improving nutrition and fluid balance recording, improving mouth care and introducing a walk round handover. The ward manager told us that staff on the ward were consulted and contributed to identifying / choosing the goals for the month.

**Culture**

Staff said the culture had improved and was more open.

Staff supported each other well and there was good team work. Teams we spoke with were proud of the services they provided to patients.

We found staff to be friendly, helpful and enthusiastic. They said they felt invested in and that the trust valued and appreciated them.

Staff we spoke with were aware of the trust values of caring, improving, respect and high standards which were underpinned with expected behaviours. We saw these displayed in the areas we visited.

The trust had a freedom to speak up guardian. Staff we spoke with were aware of this role and how to contact the guardian if necessary.

**Governance**

Governance arrangements were in place with clear routes for concerns to be escalated from staff to the senior management team and a clear line of escalation from the divisional team to the trust board via the board committees.

Ward managers attended a quality meeting every Tuesday. The meeting was chaired by a matron or a deputy head of nursing. The meetings were themed on a four weekly cycle to discuss falls, pressure damage, infection prevention and control and patient experience. The clinical governance lead for the Division of Medicine also attended the meeting. Information from speciality meetings was fed into the divisional governance meetings.

The Division of Medicine held monthly governance meetings which fed into the quality committee. We reviewed the minutes of these meetings and saw that risks, patient safety, incidents, safeguarding and effectiveness were some of the items discussed. Themes and trends were identified and lessons learnt. Matters to escalate to the quality committee were agreed at the end of each meeting.
The trust had a service level agreement with the local mental health trust. This provided assurance that the trust received specialist medical and administrative support to ensure they met their responsibilities and worked within the Mental Health Act and Mental Health Act Code of Practice.

**Management of risk, issues and performance**

The leadership team were aware of their main risks and were able to explain the actions in place to mitigate their risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and were regularly reviewed.

The divisional leadership team identified nurse staffing, their reliance on locum doctors and activity levels as their three top risks. They were also concerned that the regional reconfiguration of stroke services and the proposed closure of the hyper acute stroke unit at a neighbouring trust posed a risk to their services.

Staff were able to identify local risks and were clear on how to escalate this risk to their managers.

We found evidence of that managers used information to measure performance. There was a comprehensive monthly performance dashboard for the Division of Medicine. The dashboard included performance measures and information about the quality and safety of patient care. Targets were set for each area of performance and the dashboard clearly indicated (using a red/amber/green rating) which targets were met and which were not. The report enabled the senior team to have oversight of any areas where performance was lacking and required improvement and areas in which improvements had been made.

The performance report included data on safe care, staffing, performance indicators and identified issues of data quality. Data was provided in both written and graphical form to enable themes and trends to be easily identified.

**Information management**

Information management systems were used effectively in patient care and for audit purposes to monitor and improve quality.

Ward managers had access to information on individual ward dashboards called heat maps. Heat maps were available for all medical wards and contained monthly data on staffing, patient safety, infection prevention and control, patient experience and nursing quality governance. The heat map was being further developed to provide additional data to ward managers.

**Engagement**

The trust held an annual staff awards event to recognise and celebrate excellence. Staff and teams could also be nominated for ‘My Star’ awards. Winners would receive gift vouchers and were presented with a framed certificate. We saw several of these displayed in the areas we visited and staff we spoke with were proud to have won awards or been nominated.

There was a workforce of 600 volunteers at the trust who were given a certificate to thank them for their support and dedication. Long service was also recognised and rewarded.

The executive team had awarded all staff an additional day off in recognition for their hard work and efforts.

The leadership team met staff regularly at engagement meetings and received feedback from the freedom to speak up guardian. Regular staff forums took place for nursing staff and junior doctors.
The leadership team acknowledged that there were some issues affecting morale of the junior doctors and hoped the forums would help resolve some of the issues.

At the wider team meeting, therapy staff had discussed the results of the last staff survey and had worked together to form an action plan which they were taking forward.

Notice boards displayed thank you cards and letters from patients and relatives. We also saw ‘what we are proud of’ information displayed on wards.

There was a patient engagement strategy. Patient experience was discussed every four weeks at the ward manager quality meeting. A patient representative or members of the PALS team were invited to the meeting to contribute to the discussion.

The Rapid Elderly Acute Care Team (REACT) was supported by a project group which included both a patient and carer network representative and local patient representatives.

Wards displayed ‘listening to you’ boards with details of issues patients had raised and what solutions had been put in place. We saw that wards displayed a visitor’s charter which included an explanation of when / why patients no longer needed a hospital bed.

All medical wards participated in the friends and family test. Five additional questions based on the trust patient experience priorities were added to the inpatient friends and family test cards. Themes and trends from test results and complaints were used improve services to patients.

Learning, continuous improvement and innovation

Staff were encouraged to undertake a service improvement project as part of the leadership programme. Cardiology nurses had produced an information booklet for patients attending the nurses led cardiology clinic.

The division carried out of rapid improvement projects to improve services. There was support for staff who wanted to improve services.

Staff were keen to share the innovative work they were involved in. For example, the Rapid Elderly Acute Care Team (REACT) had made a presentation at the Royal College of Nursing conference.

The trust had an improvement work stream to reduce patient falls which was led by the falls prevention practitioner. The falls work stream was in collaboration with the improvement academy and commissioners and was underpinned by a comprehensive action plan. From April 2017 to January 2018 the trust achieved a 16% reduction in falls with harms against a target of 10% compared to the previous year.

The stroke unit had worked with a manufacturer of sensor mats to improve their product which was upgraded to include a flashing light to enable staff to see at a glance if the mat was operational.

Staff were rewarded for innovative work through the staff awards scheme.
The trust has 30 critical care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, The Mid Yorkshire Hospitals NHS Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric, 10.0%</td>
<td>Pediatric, 7.6%</td>
</tr>
<tr>
<td>Neonatal, 23.3%</td>
<td>Neonatal, 24.1%</td>
</tr>
<tr>
<td>Adult, 66.7%</td>
<td>Adult, 68.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The Mid Yorkshire NHS Foundation Trust has one critical care unit based at Pinderfields Hospital in Wakefield. Following reconfiguration within the trust (completed in September 2017), all patients requiring admission to critical care are transferred to Pinderfields Hospital. This facility admits critically ill patients from Dewsbury, Pontefract and regional referrals via the West Yorkshire Operational Delivery Critical Care Network.

The critical care service is a combined intensive care unit (ICU) and high dependency unit (HDU). It provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care to adult patients. The service is also a regional burns unit and has two dedicated critical care burns beds. Overall, the unit has a total of 20 beds, with capacity to care for a maximum of twelve level three patients, two level three burns patients and six level two patients.

The unit has one large bay which is split into two sides, there are six beds on each side with three isolation side room cubicles on either end of the main area. The two beds for burns patients are located across the corridor from the critical care unit on the regional burns unit.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 31 March 2018 at this site, there were 854 admissions with an average age of 59 years. Of these, 73% percent of admissions were non-surgical, 6% were planned surgical admissions and 21% were emergency surgical admissions. The average (mean) length of stay on the unit was 3 days.

The critical care outreach team (CCOT) provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The outreach team is available seven days a week from 7:30am to 7:30pm.

The critical care service is part of the West Yorkshire Critical Care Network. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. At the last inspection two key questions were rated requires improvement, these were safe and well led. We re-inspected all five key questions during this inspection.

During this inspection we visited the critical care unit. We spoke with four patients, five relatives and 39 members of staff. We observed staff delivering care, looked at eight patient records and prescription charts. We also visited Dewsbury hospital to review arrangements for transferring deteriorating patients to the critical care unit. We reviewed trust policies and performance...
information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Is the service safe?

Mandatory training

The trust set a target of 95% for completion of mandatory training.

Mandatory training – nursing staff

Following inspection, the trust provided a breakdown of compliance for mandatory training courses for critical care staff as at end of June 2018, shown in the table below. The trust was not able to provide a breakdown of the data by staff group.

<table>
<thead>
<tr>
<th>CORE SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity Awareness - Once in Employment</td>
<td>0</td>
<td>111</td>
<td>111</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Control - Every 2 Years</td>
<td>6</td>
<td>105</td>
<td>111</td>
<td>95%</td>
</tr>
<tr>
<td>Manual Handling Level 1 Theory - Every 3 Years</td>
<td>0</td>
<td>111</td>
<td>111</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Capacity Act (including DOLS) Level 1 - Every 3 years</td>
<td>111</td>
<td>111</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>14</td>
<td>97</td>
<td>111</td>
<td>87%</td>
</tr>
<tr>
<td>Health and Safety Level 1- 3 Years</td>
<td>2</td>
<td>109</td>
<td>111</td>
<td>98%</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>16</td>
<td>95</td>
<td>111</td>
<td>86%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>2</td>
<td>108</td>
<td>111</td>
<td>97%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>2</td>
<td>108</td>
<td>111</td>
<td>97%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>42</td>
<td>955</td>
<td>999</td>
<td>96%</td>
</tr>
</tbody>
</table>

Role Specific MAST Compliance (target 85%)

<table>
<thead>
<tr>
<th>ROLE SPECIFIC SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion Safety – Every2 Years</td>
<td>10</td>
<td>98</td>
<td>108</td>
<td>91%</td>
</tr>
<tr>
<td>Conflict Resolution - Once in Employment</td>
<td>19</td>
<td>93</td>
<td>112</td>
<td>83%</td>
</tr>
<tr>
<td>Health and Safety Level 2 - Every 2 Years</td>
<td>15</td>
<td>89</td>
<td>105</td>
<td>85%</td>
</tr>
<tr>
<td>Manual Handling Level 2 practical - Every 3 Years</td>
<td>2</td>
<td>105</td>
<td>107</td>
<td>98%</td>
</tr>
<tr>
<td>Medicines Management Level 2 - Every 3 Years</td>
<td>2</td>
<td>95</td>
<td>97</td>
<td>98%</td>
</tr>
<tr>
<td>Mental Capacity Act (including DOLS) Level 2 - Every 3 years</td>
<td>11</td>
<td>82</td>
<td>93</td>
<td>88%</td>
</tr>
<tr>
<td>Mental Capacity Act (including DOLS) Level 3 - Every 3 years</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>25%</td>
</tr>
<tr>
<td>Patient Safety – Every 2 Years</td>
<td>22</td>
<td>87</td>
<td>109</td>
<td>80%</td>
</tr>
<tr>
<td>Resuscitation Training - Every Year</td>
<td>8</td>
<td>89</td>
<td>97</td>
<td>92%</td>
</tr>
<tr>
<td>Resuscitation Training Every 3 Years</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>80%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 3 Years</td>
<td>15</td>
<td>92</td>
<td>107</td>
<td>86%</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>15</td>
<td>92</td>
<td>107</td>
<td>86%</td>
</tr>
</tbody>
</table>
During inspection, we reviewed local training records and we saw that the service met the trust compliance targets of 95% for core mandatory training and 85% for role specific mandatory training.

Staff told us the unit manager planned staffing rotas to enable staff to complete training modules, supported by the education team.

Role specific training was also completed, including annual training in life support, blood transfusion safety, arterial blood gases training, health and safety and diversity training. During inspection, we saw that 93% of staff on critical care had completed basic life support training at 30 June 2018. Managers told us the outreach team completed intermediate life support training and the advanced critical care practitioners completed advanced life support training.

Although sepsis training was not mandatory, information from the trust indicated nursing staff received a training presentation on sepsis as part of their core skills or skills in practice course and staff told us the specialist nurse for sepsis had provided bespoke training for critical care staff.

The clinical educator for the critical care unit managed training and compliance rates were tracked on the unit. A monthly update was also received from the organisational development team.

Although all training data was not yet collated into a single spreadsheet, the education team had an overview of the unit’s mandatory training, clinical skills and specialist skills training, including data on equipment training, supplied by the medical physics department.

**Mandatory training – medical staff**

The trust provided data for mandatory training module completion for medical staff. However, critical care staff were included within the overall anaesthetics staff group data and therefore specific figures for the critical care core service were not reported.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following inspection, the trust provided updated mandatory training data as above, including safeguarding training, however the trust was not able to provide a breakdown of this data by staff group.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module.

**Safeguarding adults and children courses – nursing staff**

Following inspection, the trust provided a breakdown of compliance for mandatory training courses including safeguarding training for critical care staff as at end of June 2018, shown in the table below.

This showed overall critical care staff met the trust compliance targets. The trust was not able to provide a breakdown of the data by staff group.

<table>
<thead>
<tr>
<th>Core MAST Compliance (target 95%)</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE SUBJECTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>2</td>
<td>108</td>
<td>111</td>
<td>97%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>2</td>
<td>108</td>
<td>111</td>
<td>97%</td>
</tr>
<tr>
<td>Role Specific MAST Compliance (target 85%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
During inspection, managers showed us training records which showed 100% of eligible staff on critical care had completed safeguarding adults and children level one training and 89% had completed level two training by 30 June 2018. This exceeded the trust target of 85%.

We saw that 80% of staff had also completed PREVENT training.

Trust policies and guidance relating to safeguarding were available on the trust intranet and staff knew how to contact the trust safeguarding team for further advice. Staff we spoke with had knowledge of the service available and were confident with regard the referral process surrounding safeguarding. We saw that safeguarding concerns were escalated, documented and communicated as per policy and process. For example, we observed staff sensitively managing a situation where a patient’s relative informed the team of a potential safeguarding issue. The relative expressed concerns regarding another family member visiting the unit. There had been previous history surrounding verbal and aggressive behaviour; they felt vulnerable and were concerned about repeat issues within the department. The staff team communicated and documented the information and made a referral to the Safeguarding Advisor.

There was a trust policy for the treatment of agitated patients and the unit used regional critical care network guidance where sedation was used in treatment.

**Safeguarding adults and children courses – medical staff**

Following inspection, the trust provided updated mandatory training data as above, including safeguarding training, however the trust was not able to provide a breakdown of this data by staff group.

**Cleanliness, infection control and hygiene**

During inspection, managers showed us training records which showed 96% of eligible staff on critical care had completed both infection prevention and control training and training in aseptic non-touch technique training, at 30 June 2018.

Following inspection, we reviewed as completed monthly infection and prevention control audit provided by the trust for June 2018. This showed the unit had achieved 100% compliance in relation to hand hygiene, cleanliness of the clinical environment, sharps safety and appropriate isolation of patients with an infection.

Environmental audit scores for the unit in July 2018 were 97% for housekeeping checks and 94% for nursing checks. We saw the unit achieved 100% compliance with the regional critical care network ventilator associated pneumonia audit, in July 2018.

We saw information displayed on cleanliness and infection control on the safety information board which showed there had been no unit-acquired cases of methicillin resistant staphylococcus aureus (MRSA) infections on the unit since October 2016 and no clostridium difficile infections since April 2016.

Intensive Care National Audit and Research Centre (ICNARC) data showed there had been 0.2 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 March 2018 at Pinderfields hospital. This was better than similar units. For the same time period there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA) or clostridium difficile.

The unit was visibly clean, tidy and dust free. Hand hygiene points were visible at the entrance of the critical care reception area and the critical care unit. Signage was visible regarding infection control across the unit, alcohol hand gel was available at every bed space. We spoke with domestic and housekeeping staff who were aware of policy and processes for cleaning the ICU environment and we saw daily cleaning schedules for specific areas had been completed.
We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene, personal protective equipment (PPE) and isolation. Staff told us the unit had link nurses for infection prevention and control. We saw information on display about preventing legionella and how to manage blood spills.

The unit had facilities for respiratory isolation and we found appropriate waste segregation and disposal systems in place. During inspection we saw appropriate handling of sharps by unit staff, however we also observed multiple handling of sharps boxes during their collection and removal from the unit to the holding area. This process and the equipment used presented some risk of sharps injuries which had not been identified by staff. This was fed back to the senior management team during inspection.

Environment and equipment

The unit was compliant with health building notice (HBN) 04-02 and had windows allowing natural light into the bed space. Access was via intercom with a security camera. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance and managed in line with agreement with commissioners. There were six single rooms available. In the main bay, bed spaces were separated by curtains to maintain patients’ privacy and dignity.

There was direct access to theatres via a corridor from the unit. The two beds for burns patients were located across the corridor, on the regional burns unit. The unit has a central dirty utility, blood laboratory storing point of care equipment (POCT), central store, pantry area and a medicines store. All storage areas were well maintained and stock levels were managed by a dedicated health care assistant and pharmacy assistant.

The replacement of equipment was part of the trust wide capital replacement programme. Six haemofiltration machines had recently been purchased. Training for new equipment introduced to the unit was provided by the manufacturer and refresher training and competency checks were carried out by clinical educators annually. The clinical educator tracked equipment training on the unit training database and via the medical physics team. Managers showed us training records which indicated 82% staff had completed haemofiltration equipment training and 90% of staff had completed ventilator refresher training since January 2018.

There was adequate equipment in the unit to meet the needs of patients. We saw that specialist equipment was available for patients with a high body mass index (BMI) when required. A standard hoist and bariatric hoist were available on the unit and a bariatric commode was stored on the adjacent burns unit. We checked 16 pieces of equipment and found evidence of up to date electrical safety testing.

Appropriate emergency equipment was available at each bed space and there as a resuscitation trolley centrally located on either side of the unit. Staff explained the difficult airway trolley had been incorporated into the resuscitation trolley to reduce the amount of room required at the bed space in an emergency. We saw both resuscitation trolleys were clearly labelled and checked daily in line with trust policy. We saw daily checklists were checked by senior staff during weekly spot checks.

The unit had six in house patient transfer bags and one external patient transfer bag on the ICU. Transfer bags were clearly labelled and we saw they were checked daily, together with transfer medicines requiring fridge storage. This was in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS).

However, we found the safety of equipment available for patient transfers from Dewsbury hospital theatres to critical care at Pinderfields was not regularly checked, in line with GPICS. Although there was a log book, daily checks had not been completed since January 2018 and there was no contents list or cleaning schedule to check against. Some emergency medicines and equipment were out of date and one of the portable oxygen cylinders on the trolley was empty. We raised this with managers during inspection who responded immediately. The following day, we saw that the transfer trolley and transfer bag had been checked, equipment and medicines replaced and responsibility for checking and cleaning procedures had been adjusted and reinforced. Staff told us patients were usually transferred via paramedic ambulance or from the emergency department at Dewsbury and so the theatres trolley was rarely used.
It was acknowledged that the main ward ventilation system did not meet the GPICS standard. This had been identified by staff, recorded on the risk register and appropriate controls put in place to reduce the risk of airborne infections. For example; portable air filter units at each bed area, regular air sampling and surveillance. Major building work was required to rectify the problem which required the critical care unit to be relocated for a prolonged period of time. The unit were planning for this remedial work to begin in June 2019.

Assessing and responding to patient risk

The critical care outreach team (CCOT) supported medical and nursing staff on the wards when they were caring for deteriorating patients and admission or transfer to critical care was required. This team of nurses visited planned patients before they came to ICU. They attended cardiac arrest calls and provided support to patients with tracheostomies and patients who required non-invasive ventilation; continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BIPAP). The CCOT also reviewed patients who were stepped down from critical care to the wards, offering support and guidance to ward teams. The team were based at Pinderfields hospital and provided cover seven days a week from 7:30am to 7:30pm. Staffing had recently been increased to two nurses per shift. We noted that capacity had increased since our last inspection, when the CCOT was only available until 6pm. After 8pm, ward staff could contact the ICU co-ordinator bleep-holder for advice.

The Trust used the national early warning score system (NEWS) as a tool for identifying when a patient's condition may be deteriorating. The wards used an electronic system in place for recording patient observations. This software highlighted patient outlier statistics relating to blood pressure, temperature, pulse and oxygen saturation. This system allowed the CCOT team secure remote access to patient data, enabling them to identify and respond to patients with elevated NEWS scores across the Pinderfields site.

Staff told us that patients with a tracheostomy or laryngectomy would now also be referred to the outreach team and flagged on the electronic system, so they could give appropriate support and education to ward staff. All patients with a tracheostomy must have communication and swallowing needs assessed when the decision to wean from the ventilator has been made and the sedation hold has started. Information provided by the trust indicated that the unit was not compliant with this GPICS requirement, as the staff do not routinely complete swallow assessment on patients prior to weaning although it was completed during the weaning process. This was an area of development identified by the unit.

Although there was no critical care outreach team on site at Dewsbury, we saw that an advanced critical care practitioner (ACCP) monitored patients’ NEWS scores on the surgical wards, supported staff and arranged transfer to ICU at Pinderfields if required. Ward staff could contact the outreach team at Pinderfields for telephone advice or out of hours, the anaesthetist on call. On the medical wards, staff told us they pro-actively transferred patients with the potential to deteriorate overnight, to Pinderfields, to facilitate access to critical care and minimise the need for emergency transfers.

Following inspection, the trust provided audit information on NEWS scores. An audit carried out by the outreach team in September 2017 showed 84% of deteriorating patients at Dewsbury hospital had their observations recorded on time, against a trust target of 85%. The trust provided assurance data to show that from February to April 2018, six of seven ward areas at Dewsbury had consistently achieved 85% or more observations on time, each week. We also saw staff on one ward at Dewsbury had developed a sepsis trolley.

Staff told us that patient risk and potential need for critical care was considered in deciding whether surgical procedures would take place at Dewsbury or Pinderfields. Theatre staff explained only low risk elective procedures were scheduled at Dewsbury and sometimes the whole theatre team would be moved to Pinderfields to ensure critical care was readily available, if required. A transfer trolley and equipment was located in theatres at Dewsbury, which staff told us was rarely used.

The critical care unit had a standard operating procedure for management and transfer of deteriorating patients which reflected the service reconfiguration in September 2017 and used the regional critical care network transfer guidelines which reflected national guidelines. Staff told us
that in practice, deteriorating patients were usually transferred to Pinderfields via paramedic ambulance and not the transfer trolley in theatres. The on-call anaesthetist could also accompany a patient, as required. From Pinderfields, the outreach team would accompany internal and external patient transfers. An internal transfer checklist was used to check equipment when patients went for diagnostic screening and the regional network transfer guidelines were used when patients were transferred to another site. Following inspection, the trust advised that all transfer requests were recorded by the anaesthetic department and an audit was underway with a view to service improvement.

The unit did not accept paediatric admissions. In the rare event of a paediatric admission both critical care and paediatric teams managed children jointly and staff accessed the dedicated intensive care transport service for children as needed.

We saw that sepsis screening tools and pathways were in use, in line with guidance from the National Institute for Health and Care Excellence (NICE). Policy information was available to staff on the trust intranet page and staff told us the specialist nurse had provided training on the sepsis tool. We saw trust-wide data which indicated 98% of inpatients and 93% of patients admitted via the emergency department, were screened for sepsis from April 2017 to March 2018. This also showed the sepsis care bundle was initiated within one hour for 60% of inpatients and 66% of patients admitted via the emergency department. The audit highlighted the need for good documentation using the sepsis screening tool.

During inspection, managers showed us training records which showed 96% of eligible staff on critical care had completed training in aseptic non-touch technique training, at 30 June 2018.

The eight patient records we reviewed included completed risk assessments for falls, pressure areas, nutrition, venous thromboembolism (VTE) and ventilator associated pneumonia (VAP) and appropriate actions in place.

We saw evidence of screening for delirium in the eight patient records we reviewed in line with NICE guidance. There was a trust policy for the treatment of agitated patients and the unit used regional critical care network guidance where sedation was used in treatment.

The trust provided us with the surgical division dashboard (of which critical care is part) and this showed that 98% of VTE risk assessments were completed for eligible patients (from May 2017 to Jan 2018), which was above the trust target of 95%.

Staff we spoke to knew how to access mental health support and were confident in the referral process. There was access to specialist nurses and a crisis team. The unit did not have a dedicated psychologist although staff told us they could go to the psychologist on the burns unit for advice, informally.

**Nurse staffing**

The critical care team had an establishment of 108.65 whole-time equivalent (wte) registered nurses and 10.48 (wte) non-registered band 2 care staff. They were supported by one band 3 and 2.15 (wte) band 2 admin and clerical staff.

According to information provided in the PIR, there were 101 registered qualified nurses in post, plus one advanced critical care practitioner (ACCP) and two ACCP trainees, a total of 92.62 whole-time equivalent (wte) staff. The outreach team had 5.9 wte registered nurses.

When fully staffed, managers planned staffing based on an average of three level 3 admissions per shift and less than 20% of agency staff. Managers told us the staffing establishment had changed and the two ICU burns beds were now staffed for 1.5 nurses to one patient to mitigate their location, separate to the main bay. Similarly, when patients were nursed in side rooms, staffing was usually adjusted to allow for a ‘runner’.

During inspection, we reviewed staffing data for two weeks in June 2018 and we compared the number of actual staff on duty against the dependency of the patients. We found the unit always met the minimum ratio of one nurse to one level three patient and one nurse to two level two patients. We also observed this to be the case during inspection.

Following inspection, we reviewed information from the trust’s public website on the fill rates for registered nurses. The fill rates on the unit for the day shift were 75% January 2018, 77% in February 2018, (March data was not available), 71% April 2018 and 96% May 2018. The fill rates
on the unit for the night shift were 74% January 2018, 71% in February 2018, (March data was not available), 67% April 2018 and 70% May 2018.

Following inspection the trust explained that the ‘planned number’ used to calculate the fill rate was based on a maximum average and therefore tended towards a higher number than actually required based on the ward to achieve the GPICS standards. Managers told us the unit was staffed daily in accordance with the level and number of patients on the unit. Managers told us the required nurse to patient ratios were achieved through daily review of the number and level of patients on the unit including capacity for the burns beds and to the standards set in the Guidelines for the Provision of Intensive (GPICS). The unit was staffed to deliver a minimum of 1:1 registered nurse/patient ratio for level 3 patients and 1:2 for level 2 patients, in addition to a clinical co-ordinator (and when required an additional registered nurse in a supernumerary capacity, to oversee delivery of care on the unit.

We discussed staffing with managers and it was identified as an ongoing challenge, although gaps in staffing were usually filled by the substantive critical care staff, working bank shifts. Managers explained nurses were often moved to work in other areas, on the understanding they could return to the unit, as required. Following inspection, we requested information from the trust on the number of staff moved which showed an average of 68 staff were moved each month from January to June 2018. Although managers were aware that staff were frequently moved to other areas and there was an impact on morale from this, staff told us there was a fair system in place for deciding staff moves. New staff were not moved from the unit during their first six months. Agency staff were not moved, although this was an area for review. Senior staff were not moved if they were needed to ensure sufficient skill mix and supernumerary support. Staff moved to the wards were not generally allocated a cohort of patients, so they could return to critical care as required.

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 18.7% for nursing staff in critical care. This is worse than the trust target of 9%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of inspection, managers told us six nurses were due to start in September and there were five further band 5 and one 0.5 band 7 wte registered nurse vacancies. Interviews were in progress at the time of inspection. The outreach team did not have any vacancies. The unit had hosted several recruitment open days specific to critical care in recent months which managers told us had proven successful in attracting candidates. Managers described a further international recruitment programme which was in progress, with nurses due to join the trust towards the end of 2018.

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.1% for nursing staff in critical care. This is better than the trust target of 12%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 7.2% for nursing staff in critical care. This is worse than the trust target of 4.8%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

At the time of our inspection, managers told us the sickness rates was currently 8% for nursing staff. The unit manager explained they had recently begin working with occupational health and human resources to complete a ‘deep dive’ investigation to try and manage sickness absence
(June 2018). This had been discussed at divisional management meetings. Managers were starting to work with occupational health, to introduce wellbeing sessions and to learn from other trusts at regional network meetings.

**Bank and agency staff usage**

The trust did not report any bank or agency usage within critical care.

*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

Managers planned staffing based on an average of three level 3 admissions per shift and less than 20% of agency staff which was in line with GPICS. The unit used an agency that provided critical care trained staff.

We saw there was a register and induction checklist for agency staff to complete on their first shift on the unit. We found that although staff completed the register and we saw evidence of some completed checklists, not all the completed checklists were in evidence (e.g. for November 2017) and staff were unable to locate them.

**Medical staffing**

Critical care had a designated clinical lead. Care was led by a consultant in intensive care medicine which was in line with GPICS standards. A consultant was present on the unit from 8:00am to 19:45pm on weekdays and until 15:30pm on weekends. A second consultant was present on the unit from 8:00am to 16:00pm Monday to Friday working on a ‘hot week’ block to meet staffing ratios and provide continuity of care in line with GPICS.

We saw that since the last inspection consultant rotas and on call arrangements had changed since the service reconfiguration which brought the unit in line with GPICS standards; ‘hot week’ block working was now in place which delivered continuity of care and consultants were freed from other commitments when on call and when on ICU daytime duty.

We observed a consultant led ward round and handover which was clear with detailed plans outlined for each patient. In the eight patient records we reviewed, we saw that daily consultant led ward rounds took place, which was in line with GPICS standards.

During this inspection, the consultant to patient ratio did not exceed the recommended 1:8 to 1:15. This had improved since our last inspection, when the patient to resident doctor ratio was not in line with GPICS standards out of hours.

During this inspection, we saw that members of the multidisciplinary team including physiotherapist and pharmacist, now routinely completed daily ward rounds. Although these were not always completed at the same time as the consultant ward round, there was evidence of structured MDT input into discussions about patient care, which had improved since our last inspection.

**Vacancy rates**

The trust provided data for vacancy rates for medical staff. However, critical care staff were included within the overall anaesthetics staff group data and therefore specific figures for the critical care core service were not reported.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

The trust provided data for turnover rates for medical staff. However, critical care staff were included within the overall anaesthetics staff group data and therefore specific figures for the critical care core service were not reported.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*
Sickness rates

The trust provided data for sickness rates for medical staff. However, critical care staff were included within the overall anaesthetics staff group data and therefore specific figures for the critical care core service were not reported.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust did not report any bank and locum usage within critical care.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

At our previous inspection, staff told us there was a high usage of locum doctors. Information on medical locum use was requested however the trust were unable to provide this specifically for critical care within a reasonable timescale as it was included and managed as part of the anaesthetics group of staffing rotas.
During the last 12 months, staff told us there had been no use of external medical locums in critical care and any uncovered sessions would be covered by medical staff already known to the unit. Staff told us locum usage had reduced following the hospital reconfiguration in September 2017 and there was an induction pack for locums.

Records

Nursing and medical records were stored securely in a trolley at the end of each bed space or outside the room of those patients requiring isolation. Managers showed us information during inspection which showed 92% of critical care nursing staff had completed information governance training by 30 June 2018, although information from the trust put this figure at 86%, against the trust target of 95%.

We reviewed nine sets of paper based nursing and medical records in detail looking at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. We saw care pathways and risk assessments in use, for example for pressure area care and patients with indwelling lines. There was evidence of holistic assessment including, for example, information about patients’ mental health needs.

Medical records were completed in line with trust and professional standards, for example we saw evidence that patients were reviewed by a consultant within 12 hours of admission and daily MDT input.

A weekly assurance audit was completed by senior nurses included checking patient records, including that relevant risk assessment, clinical checklists and care plans were completed. We reviewed three examples from July 2018 and saw that risk assessments and clinical checklists were appropriately completed.

An audit of the sepsis care bundle (March 2018) highlighted the need for good documentation using the sepsis screening tool.

We saw the physiotherapy team completed records that met the NICE Guideline CG83 (rehabilitation after critical illness) requirements during a patient’s stay in critical care. We reviewed audit data from the physiotherapy team which showed 87% of patients received a documented initial therapy assessment within 24 hours of admission, against a target of 90%. The peer review report (Dec 2017) had included a green RAG rating in relation to National Institute for Health and Care Excellence (NICE) CG83: rehabilitation after critical illness, rehabilitation prescriptions for patients leaving critical care.

In the records we reviewed, we saw admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) Guideline CG50 (acutely ill patients in hospital). CCOT staff told us discharge information was thorough with clear escalation plans for individual patients and we saw information was included with clear guidance on care, risks and
ongoing care requirements. Managers told us that documentation had been redesigned to collect data on the time of decision to admit and admission and discharge and that this was audited. The electronic system for recording observations was not used on the unit, however once a patient was ready to transfer to a ward the outreach team would add their most recent observations to the electronic NEWS system.

**Medicines**

During our inspection we found medicines were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records and saw that accurate records and checks were completed in line with trust policy. Controlled drugs stock was checked at each handover shift by the nurse in charge and a quarterly audit was completed by the pharmacy team. A six-monthly storage and security of medicines audit report provided by the trust showed critical care was compliant with trust policy in April 2018. The trust had a central system to monitor fridge temperatures in line with trust policy to ensure medicines requiring refrigeration were stored safely. Staff told us the unit was informed when a fridge was outside of the safe temperature range and we saw evidence of appropriate action being taken.

A specialist critical care pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patient medicines. There was access to pharmacy provision via the inpatient pharmacy on Saturdays, Sundays and Bank Holidays and access to on call pharmacy provision at other times. There was one advanced critical care practitioner (ACCP) and two trainees, who were non-medical prescribers. We reviewed eight medicines charts and we noted that oxygen was not routinely prescribed on the medicines chart. The trust medicines management policy did not specifically refer to oxygen prescribing although the chief pharmacist told us they would expect oxygen to be prescribed in line with national guidance; every ward area had a designated nursing officer for medical gases.

Apart from oxygen prescribing, we found the medicines charts we reviewed to be completed in line with trust and national guidance. Each chart had been reviewed by the pharmacist and allergy status had been completed. Senior staff told us a new chart had been introduced with clinical indication and start and stop dates for antimicrobials. The medicines charts we reviewed had antibiotics prescribed in line with national guidance. We saw that one patient’s weight and height were not recorded on one chart, although this was recorded on the renal (filtration) prescription chart prescription.

During inspection, we saw training records which showed 98% of eligible staff on critical care had completed medicines management training at 30 June 2018, which had improved since the last inspection. Staff we spoke with were aware that patients should resume normal medication while sedated e.g. for mental health conditions.

We noted the serious incident investigation had highlighted there was no oxygen cylinder training / medical gases training in place at the time across the trust. The chief pharmacist told us annual medical gases training was now in place and data from the trust indicated two designated nursing officers on the critical care unit had completed training.

We reviewed incidents data from April to June 2018 and we saw that medicines incidents accounted for 5% of all reported incidents in this period.

Staff described one example of learning from a medicines incident where the antimicrobial pharmacist found staff had incorrectly been using actual weight rather than ideal weight and thereby prescribed the wrong dose. The pharmacist was involved in speaking with consultant teams in critical care and doctors in training to raise awareness of correct prescribing of antibiotic medicines. We saw that medicines were discussed at clinical management group meetings.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers...
follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for critical care.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in critical care which met the reporting criteria set by NHS England from May 2017 to April 2018. The incident was classified as:

- Medical equipment/devices/disposables incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

We reviewed incidents data from April to June 2018. There were 124 incidents reported during this period and all resulted either in no harm (87%) or low harm (13%). Of the total number, 82 (68%) were due to a delayed transfer from critical care due a suitable bed not being available within the four hour transfer window. The next most common incident type (10%) related to pressure injuries, then administration of medicines (5%) and transfusion of blood related problems (5%).

Staff told us themes and trends were discussed at staff meetings and handovers to raise awareness and share learning and we saw actions taken in the two sets of management team minutes we reviewed, although these meetings were not routinely attended by frontline staff. For example, the service had used matron spot check audits and education to address the number of level 2 pressure ulcers on the unit related to use of devices. Senior staff told us the unit was an outlier for grade 2 pressure ulcers and this had been logged on the risk register. Managers were looking into alternative equipment for securing devices and had approached the West Yorkshire critical care network, to benchmark themselves against similar services.

We saw learning points from incidents, actions from medicines audits and equipment updates were included in the handover safety brief. We saw that refresher training and step by step guides on ventilator equipment had been introduced following two no harm incidents. We saw incidents, lessons learned and actions taken, were recorded in the unit management team minutes and in the anaesthetic group and clinical governance minutes we reviewed and in the nursing handovers we observed, although it was not clear how learning was shared with the MDT.

We discussed the serious incident with the consultant anaesthetic lead on the unit and we reviewed the investigation report following inspection. The incident related to an equipment problem while a patient from ICU was transferred to radiology for diagnostic tests. A root cause analysis investigation and action plan had been completed and the investigation involved appropriate professionals from other specialities. We saw that lessons learned were discussed at clinical governance meetings. We saw an internal transfer checklist had been introduced in critical care to prompt staff to ensure that equipment checks have been completed prior to moving a patient within the hospital, for example, for diagnostic imaging. Staff were collecting data for an audit of the checklist. However, we noted that the checklist was not used for cross-site transfers between trust sites. The investigation report also recommended annual medical gases training for all nursing staff and a review of transfers and decision-making and we were provided with an action plan which indicated this had been completed.

Staff told us that weekly mortality and morbidity meetings took place and manager explained this was an area of improvement for the unit. We reviewed two sets of mortality and morbidity meeting minutes and we saw that individual case note reviews took place, with members of the clinical, nursing and education teams. However, managers recognised the meetings were not well-structured or recorded and it was not clear how learning points were systematically logged and actions arising were monitored for service improvement. It was unclear how themes and the learning process was shared with the wider team, for example MDT colleagues and staff from other areas, who had also been involved in a patient’s care.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported six new pressure ulcers, no falls with harm and no new catheter urinary tract infections from April 2017 to April 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Mid Yorkshire Hospitals NHS Trust**

![Graph showing pressure ulcer data](image)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Safety thermometer data was displayed on the patient safety board in the waiting area. This showed that critical care reported no new grade 3 or 4 pressure ulcers, no falls with harm and no new catheter urinary tract infections in the 12 months to May 2018.

Staff told us themes and trends were discussed at handovers to raise awareness and share learning and we saw actions taken in the two sets of management team minutes we reviewed.

Is the service effective?

Evidence-based care and treatment

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Policies and guidance were accessed on the trust intranet which was easy to navigate. We saw that each bedspace also included a clinical support folder for level 2 and three patients. There were up to date guidelines with information on drug compatibility. This folder also contained relevant clinical information regarding all body systems including anatomy, physiology and infection control.

Staff told us the trust used the regional critical care network guidance for sedation and we saw there was a flow chart to help staff decide if sedation holding was appropriate.

The policies we reviewed e.g. operational policy, patient transfer policy, were up to date, reflected the service reconfiguration and included review dates.

The trust was part of the West Yorkshire Critical Care Operational Delivery Network (WYCCODN). This group met six times a year to representatives from each trust in the network. They shared and reviewed critical care specific guidance from their units. This included areas such as pain,
sedation, delirium, prone positioning and nutrition. Each area was marked against a standard framework and given a score. The unit with the highest score shared their guidance with the rest of the group. If it was identified that there was a particular area or topic for which there was not guidance available, the group would develop some. We saw the unit used the network best practice guidance, for example in relation to transfers and sedation.

The WYCCODN also carried out peer reviews of services. We noted that the last WYCCODN peer review of the Pinderfields unit, (Dec 2017), identified that the trust was not fully compliant with GPICS in several areas, for example; post-registration staff qualifications, microbiology input. The management team had developed a gap analysis and action plan against this, which formed part of the draft strategy for the unit.

We saw evidence of screening for delirium in the eight patient records we reviewed in line with NICE guidance. Staff we spoke with gave an example of managing a patient with delirium when sedation was withdrawn and were aware that patients should resume their usual medication while sedated e.g. for an existing mental health condition.

We saw evidence of screening for sepsis in the patient records we reviewed, in line with NICE guidance. Staff we spoke to were aware of sepsis and the referral process to follow.

We saw evidence of staff managing conflict and aggression on the ward and staff gave examples of where they had used distraction techniques from their training e.g. offering to bring a favourite snack to an aggressive patient brought calm to a challenging situation. Managers showed us training records which showed 85% of staff on critical care had completed training in conflict resolution, at 30 June 2018.

The physiotherapy team told us they were usually able to deliver 45 minutes of daily therapy in line with GPICS guidance. Managers told us that although there were now sufficient staff (three whole-time equivalent physiotherapists) for the number of patients the unit and staff were beginning to log daily active therapy time, it was not easy to evidence this and it had been highlighted as an area for development in the draft strategy and action plan.

We saw admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital; discharge was planned and the patient, carers and family were informed of planned discharge and next steps. There was a trust discharge policy and care pathways to record the admission/discharge, including details of planned care within the community if appropriate e.g. district nurse, home help assistance etc. The trust told us they were currently compliant with CG50 with regards to the outreach team, although had not completed any gap analysis against network standards.

**Nutrition and hydration**

Nursing staff assessed patients’ nutrition and hydration needs using the malnutrition universal screening tool (MUST). We saw this had been completed appropriately in the patient records we reviewed.

We saw that a dietician completed a daily ward round on the unit to review patients and on call support was available at weekends. Staff told us a speech and language therapist attended the unit when staff referred patients.

The unit had a protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available. There was also a link nurse for nasogastric feeding.

During inspection we saw that water was available for those patients able to drink. Assistance was provided as required for those patients able to eat and we found fluid balance charts were fully completed in each of the records we reviewed.

**Pain relief**

During inspection, we saw that pain relief was discussed on ward rounds and reviewed by the pharmacy team. Pain observation tools were available for patients who could not verbalise they were experiencing pain. In the patient records we reviewed, we found evidence of documented pain scores and appropriate action taken to support patients who required pain relief.
The patients and relatives we spoke with, said pain control was effective and provided in a timely way. Information from the trust indicated no audits were completed relating to pain relief.

**Patient outcomes**

**ICNARC Participation**

In 2016/17, the trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.  
(Source: Intensive Care National Audit Research Centre (ICNARC))

There is no longer a critical care service at Dewsbury and district hospital. From September 2017 all patients requiring critical care treatment are transferred to the Pinderfields site.

Following inspection, we were provided with updated data from April 2017 to March 2018 for Pinderfields, which has been used in this report.

**Hospital mortality (all patients)**

We reviewed data from the 1 April 2017 to 31 December 2017 quarterly quality report, this showed the risk adjusted hospital mortality was 1.09, this was within the expected range.  
(Source: Intensive Care National Audit Research Centre (ICNARC))

We reviewed data from the 1 April 2017 to 31 March 2018 ICNARC quarterly quality report for Pinderfields, this showed the risk adjusted hospital mortality was 1.15, this was within the expected range.

**Pinderfields Hospital**

For Pinderfields Hospital, Critical Care Unit at Pinderfields Hospital, the risk adjusted hospital mortality ratio was 1.2 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.1.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>717 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.1</td>
<td>1.2</td>
<td>1</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

We reviewed data from 1 April 2017 to 30 September 2017 ICNARC quarterly quality report, this showed the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.18, this was within the expected range.

**Hospital mortality (for low risk patients)**
The unit had an unplanned readmission rate within 48 hours of 0.5% for the period of 1 April 2017 to 31 December 2017. This was lower (better) than the rate for similar units which was 1.5%, and was within the expected range when compared to the England average.

The ICNARC data from 1 April 2017 to 30 September 2017 ICNARC quarterly quality report, showed the unit had an unplanned readmission in 48 hours rate of 1%. This was in line with similar units’ rate of 1.3%.

**Pinderfields Hospital**

For Pinderfields Hospital, Critical Care Unit at Pinderfields Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.2. This was within expected range. The figure in the 2015/16 annual report was 0.8.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>454 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>0.8</td>
<td>1.2</td>
<td>1</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

The ICNARC data clerk and reception team worked with clinical staff to collect information the service used for research and audit.

We discussed audit with the unit manager, who explained that a variety of audits were undertaken on the unit, but there was no critical care audit calendar in place. Following inspection, we were provided with an audit plan which identified the interval and lead staff for each trust audit. However, we also saw some clinical audits noted in the clinical governance minutes which were not included here. We did not see any local audit activity relating to the outreach team. We saw that clinical audits were noted at the monthly management team meetings, although it was less clear how learning from audits was shared with staff on the unit and acted upon.

The trust provided examples of regular trust audits undertaken. Senior nursing staff completed the trust’s front line ownership (FLO) assurance audits monthly.

A weekly assurance audit was completed by senior nurses to check patient care on the unit and results were emailed to staff. We reviewed three examples for July 2018 and saw this included checking that resuscitation and other equipment was ready for use, that patient risk assessments and care plans were correctly completed and acted on (for example turning patients and using protective pads to reduce risk of pressure injury); that care plans were up to date and conversations with relatives were recorded.

We also reviewed a physiotherapy audit which showed 87% of patients received a documented initial therapy assessment within 24 hours of admission, against a target of 90%. Staff told us the results were fed back to the physiotherapy teams via staff meetings and clinical governance meetings. The physiotherapy team used a national rehabilitation outcome measure called the ‘Chelsea Critical Care Physical Assessment Tool’ (CPAX), a scoring system to measure physical morbidity in critical care patients. The team were planning to undertake audit of CPAX in August 2018 to understand how effective this is.

The critical care outreach team (CCOT) carried out an annual audit on the effective use of NEWS and escalation of deteriorating patients across the trust (September 2017) which we saw had been used as a tool for improvement across the trust, in timely patient observations.

We saw there was a standard operating procedure which indicated the outreach team would audit transfer trolley equipment checks at Dewsbury every three months, however staff told us these had not been implemented since the reconfiguration.
The service had produced a draft action plan in response to peer review report (Dec 2017) which formed part of the critical care draft strategy and action plan.

Competent staff

Appraisal rates

From April 2017 to March 2018, 63% of nursing staff and 78% of support staff within critical care at the trust received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>7</td>
<td>9</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>92</td>
<td>58</td>
<td>63%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Following inspection, information provided by the trust showed 99% of staff had received an appraisal. This was above the trust target of 85%.

Information provided by the trust showed the medical staff appraisal rate (consultant and non-consultant) was 100% at 30 June 2018. This was above the trust target of 85%.

During inspection, managers showed us records which showed 100% of nursing staff on critical care had received an appraisal by 30 June 2018. This exceeded the trust target of 85%.

The unit manager explained that appraisal groups had been formed to identify clear reporting lines and responsibility for nurses’ appraisals. Progress towards Step 1 compliance for new starters was monitored via the appraisal process.

All registered nurses are required to complete Step 1 of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the unit. Support to complete this was provided by the critical care clinical education team through a 12 week programme. Step one competencies have been designed to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor and/or practice educator. The education team logged the type of experience nurses were gaining, for example with level 2 and 3 patients to track progress and facilitate skills development.

The unit supported student nurse and midwife placements.

Nursing staff, including students, told us they felt well-supported. While completing Step 1 competencies; there was a mentor and buddy system in place, time to complete training and support from the education team.

Staff told us that training was openly encouraged and protected time allocated to enable attendance.

There was a critical care education team in line with GPICS standards; one full time clinical educator and two part-time support educators. They provided a variety of education inputs and maintained central records for equipment training, mandatory training and post-registration training on the unit, although some device training records e.g. for pumps, were kept by medical physics. This included a monthly education session; an annual care of the critically ill study day, incorporating basic life support and refresher training in key equipment; and a new drop-in session which could be tailored for staff to seek support on specific issues. The education team also ran simulation training for staff, for example, managing a difficult airway, where they could be assessed on their core skills. A simulation room had been created on the unit for this purpose.

The unit could access link nurses, for example, in nasogastric feeding, end of life care, and infection prevention and control.

Nurses in the critical care outreach team (CCOT) had completed training in arterial blood gases.
Managers had secured funding for two band 5 nurses to work in a band 6 development role for nine months.
At the previous inspection, there was no evidence that staff competency on key pieces of equipment was reviewed regularly. At this inspection, we saw records to indicate staff completed update training on medical devices and training records were monitored and updated by the education team. For example, we saw that 90% staff had completed ventilator update training delivered by the education team, within the last 6 months. We saw the education team was reviewing records to ensure evidence of competencies and training were accurately logged for all staff following the reconfiguration.
Managers told us nursing staff competency in using key medical equipment was reviewed every two years, for example ventilators and haemofiltration equipment. Competency in using infusion pumps was reviewed every five years, as per trust policy. New medical staff received training on key equipment during induction and for any new equipment. Training records for medical staff were maintained by medical physics team.
We were provided with an example training competency for use of a blood gas analyser for new and updating staff, which could include non-registered care staff.
Following inspection, we requested information on transfer training. The trust told us this was not mandatory although they were supporting nursing staff to attend a new course run by the regional critical care network on a quarterly basis.

**Post-registration training**

Only 35 of the 102 qualified nurses (of which one is an Advanced Critical Care Practitioner (ACCP), and two are trainee ACCPs) have a post registration award in critical care nursing.

*(Source: Trust Provider Information Request P14/P49)*

Information provided by the trust showed that 37% of staff in the service had a post registration qualification in critical care, including the ACCP and the two trainee ACCPs. This was below the GPICS minimum recommendation of 50% and had reduced since the previous inspection. This was due to 13 registered nurses having left the organisation since May 2017 (mainly due to the service reconfiguration) and 16 new starters having been recruited since, who do not currently hold the post-registration qualification.
Managers had logged this issue on the risk register and had a plan in place to increase compliance to meet GPICS by 2020, pending available training places in the region. Managers told us five new starters were on track to complete the course in July 2018 and a further eight had been allocated places to begin training in September 2018. Managers also told us all outreach nurses were band six staff and all had either completed the post-registration qualification or had more than two years critical care experience.

**Multidisciplinary working**

Staff told us there was good multidisciplinary team working on the unit and we observed this on the unit at the bedside and during ward rounds. We saw evidence of this in the patient records we reviewed.
There was a lead pharmacist, physiotherapist and dietitian for critical care and there were clear internal referral pathways to therapy services. Staff told us they had access to speech and language therapy, occupational therapy, a specialist nurse in organ donation and other nurse specialists were available when required.

At the previous inspection, multidisciplinary staffing levels were not in line with GPICS. During this inspection, we saw that MDT staffing levels, including physiotherapy were appropriate for the size of the unit, in line with GPICS recommendations. We spoke with physiotherapy staff and saw that they were able to provide the respiratory management and rehabilitation components of care, in line with GPICS recommendations.
Although therapy did not always accompany medical staff on the ward round, there was regular, structured MDT input and evidence of this factored in to planning and decision making. In the patient records we reviewed, we saw there was daily input from the pharmacist, physiotherapist and dietitian.

Physiotherapy records have been placed in packs within each patient care pathway folder to highlight physiotherapy input and plan of care, to the multi-disciplinary team.

The speech and language team (SALT) attend the critical care unit to monitor referrals via System One. The team worked with the physiotherapy team to undertake joint assessments.

The unit had ward clerks and an ICNARC data clerk.

### Seven-day services

We saw from patient records daily consultant led ward rounds took place twice daily. Consultant cover was available twenty four hours a day, seven days per week, in line with GPICS standards.

A specialist critical care pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patient medicines. There was access to pharmacy provision via the inpatient pharmacy on Saturdays, Sundays and Bank Holidays and access to on call pharmacy provision at other times. Physiotherapists provided treatment seven days a week with an on-call service available overnight.

Speech and language therapy was offered Monday to Friday.

X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

Microbiology input was not in line with GPICS standards for daily input; there was one consultant available five days a week across the trust. Staff told us they were available as needed, but this may have been by telephone rather than in person and the microbiologist did not join the ward round. However, the unit had regular access to an antimicrobial pharmacist to mitigate this. The consultant antimicrobial pharmacist led twice weekly ward rounds on the unit to educate and advise staff on appropriate antibiotic choices. Staff told us an antimicrobial pharmacist would attend the unit daily and also support a post infection review for any MRSA or CDiff infection cases.

Microbiology, pharmacy and therapy provision had been identified areas for development in the peer review (Dec 2017) and included in the unit’s draft strategy and action plan.

### Health promotion

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and staff told us the pharmacist and consultant lead intensivist would provide advice and support in such situations. Nicotine patches could also be provided to patients.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)

#### Mental capacity and deprivation of liberty safeguards courses – nursing staff

Following inspection, the trust provided a breakdown of compliance for mandatory training courses including mental capacity act and DOLS training for critical care staff as at end of June 2018, shown in the table below. This showed overall critical care staff met the trust compliance targets.

The trust was not able to provide a breakdown of the data by staff group.

| Core MAST Compliance (target 95%) | [__] | [__] | [__] |

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### CORE SUBJECTS

Does not meet requirement | Meets requirement | Grand Total | % Compliance
--- | --- | --- | ---
Mental Capacity Act (including DOLS) Level 1 - Every 3 years |  | 111 | 111 | 100%

### Role Specific MAST Compliance (target 85%)

Does not meet requirement | Meets requirement | Grand Total | % Compliance
--- | --- | --- | ---
Mental Capacity Act (including DOLS) Level 2 - Every 3 years | 11 | 82 | 93 | 88%
Mental Capacity Act (including DOLS) Level 3 - Every 3 years | 3 | 1 | 4 | 25%

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**Mental health and deprivation of liberty safeguards courses – medical staff**

The trust did not provide data for the mental capacity training modules for medical staff in the critical care core service in their RPIR.

(Source: Trust Provider Information Request P14/P49)

Following inspection, the trust provided updated overall mandatory training data as above, including mental capacity and DOLS training, however the trust was not able to provide a breakdown of this data by staff group.

During inspection, staff we spoke with demonstrated a good understanding of consent, where possible staff would always seek consent from patients. It was recognised that gaining consent within the unit could be difficult due to the patients they cared for.

Patients we spoke with told us that staff had asked their consent before treatment.

Staff we spoke with were aware of the MDT decision-making process if a patient required any form of restraint. A policy was available on the intranet and staff told us they could access specialist safeguarding nurses for advice.

Managers showed us training records which showed 92% of eligible critical care staff had completed level two mental capacity act e-learning training module, at 30 June 2018. This exceeded the trust target of 85%. In addition, 25% staff had completed the level three (workshop) course.

Staff we spoke with demonstrated an understanding of capacity, restraint and when best interests decision-making was appropriate, however due to the nature of patients in ICU, we did not see this consistently documented in line with legislation.

During inspection, we saw one example of an appropriately completed DNACPR document included at the front of the medical record.

Minutes from the divisional governance meeting (May 2018) indicated an audit to assess the quality of completed DNACPR forms on critical care unit showed they were usually well completed and no improvement actions were identified.

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**Is the service caring?**

### Compassionate care

During inspection we observed consistently kind and compassionate interactions between staff and patients.

We observed staff introducing themselves and communicating with patients regardless of whether they were conscious or unconscious, and explaining what they were doing. We observed staff patiently and calmly communicating with a patient who was unsettled, offering reassurance.
We noted that staff checked with relatives and families about individual patient needs and communication, for example did the patient use glasses, hearing aids, dentures etc. Staff responded to requests in a timely manner and knew their patients well, for example we observed a member of support staff offering to bring a preferred specific drink to one patient.

Comfort packs were available for relatives unexpectedly staying overnight on the unit. These had been developed and provided by the family of a patient who had passed away, in response to their feedback about wanting to help other families. Senior nurses had worked with the family to develop the comfort pack, offering personal toiletries which were often forgotten at difficult times, including shower gel, shampoo, conditioner, comb, toothbrush and shaving gel. The comfort bag is sponsored by the family. A card was attached to each bag explaining why it had been developed and how to make a voluntary donation to support the scheme to continue.

We saw that bed spaces were separated by curtains which were drawn when care and treatment was being delivered to maintain privacy and respect. We saw staff acting to ensure people’s privacy and dignity was maintained when required.

The consulting room was intentionally located in a more private area away from the main reception area. Relatives and families we spoke with confirmed that staff were able to support privacy and dignity during confidential discussions and difficult conversations.

We observed staff supporting families with privacy and dignity when a relative became upset and anxious; they were accompanied to the consulting room and given reassurance by the consultant. The patients and relatives that we spoke with were all positive about the care that they had received whilst on the unit. They said staff could not be better, they received good care and had no complaints. People told us they fully understood their care and staff gave good information. One person said it took time to get any information although they did find another doctor who explained things better here than on a ward.

The unit received many thank you cards from patients and their relatives. These were shared with staff and displayed in the reception area. Staff informed us that thank you cards were discussed at staff meetings and any named staff receiving good feedback valued this as evidence for their continuing professional portfolios.

Friends and family test data was displayed from May 2018 indicating 100% of respondents would recommend the service.

The staff on the unit had been nominated for, and won some trust awards for their approach. For example a nurse had been nominated by a family for the compassionate care provided to an extremely unwell patient, telling staff; ‘in the midst of all the technology, you made him feel like a person’; ‘whether conscious or unconscious, they showed absolute care and empathy’. The unit won team of the year in March 2018, for outstanding care.

**Emotional support**

A patient diary booklet was available for families and staff encouraged them to complete it. This explained how staff and relatives could make entries, and examples of what to write and how to write it. We saw that extracts from patient diaries had been shared at follow-up clinics, to help staff understand the patient experience.

Patient diaries can help patients to understand what has been happening whilst they have been critically ill. Patients who have been in a critical care environment often report memory loss and some may suffer from psychological problems. Diaries have been found to help fill in some missing gaps and have also given the patient understanding as to how poorly they have been. Relatives can also find diaries beneficial as it gives them somewhere to discuss their feelings about the patient’s illness and feel that they were doing something for the patient. We saw evidence of relatives using patient diaries and relatives told us they found the patient diary information booklet was helpful. We saw information on patient diaries was promoted by staff and in the patient information folder within reception. Staff were aware of the importance of patient feedback.

The unit did not have a psychologist on the team. Staff told us they could approach the psychologist on the neighbouring burns ward for informal advice. Managers recognised this as an
area of unmet need and were developing a business case for dedicated psychology input for critical care.

However, the service ran two groups to support patients separate to the follow-up clinics. There was a support group for patients and families to support them in coming to terms with their experience of critical care. This was intended to be more patient-led and to enable ICU survivors and families to share their experience and ask questions. Staff shared learning from patient experiences with the trust patient experience group.

There was also bereavement support from nursing staff, who sent a personalised card and letter to invite bereaved families to come back to the unit to talk informally with staff.

Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. The unit had lead consultant for organ donation and a specialist nurse, who was available 24/7. Staff made referrals via the team manager. Staff received specialist training from the specialist nurse and staff told us they felt confident regarding often difficult conversations surrounding organ donation. We saw that memory boxes were available for staff to use to support families of any palliative patient, as appropriate.

The organ donation team were committed to drive awareness and culture surrounding organ donation. They attended the regional organ donation committee four times a year and reported on referral rates, promotion, budget and education. At the time of inspection, the trust was promoting the regional organ donation campaign with ‘be a hero’ displays in hospital lifts, stairwells and shuttle buses. Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation and were aware of the referral process surrounding organ donation.

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. Contact information was available in the reception area in the patient information folder.

Staff described a recent example where they had worked with colleagues to support a family facing bereavement, to ensure a patient with complex needs could be at home to see their garden and be with relatives, at the end of their life.

Staff organised an annual memorial service for patients, relatives, carers and staff. This took place at a memorial sculpture, located on the hospital site, which had been donated by a former patient. The organ donation leads on the unit were passionate and proud of this memorial piece called ‘the tree of life’, explaining that it was a place where patients and relatives were able to leave locks marked with names and messages, to remember loved ones.

Understanding and involvement of patients and those close to them

We observed medical and nursing staff taking time to explain what was happening to relatives so they understood the care and treatment.

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.

We saw senior staff completed a weekly assurance check which included checking that conversations with relatives were recorded.

The relatives we spoke with said they felt well informed. One said they were ‘fully aware of the treatment plan and next steps’. Another explained there had been regular visits by the dietician, speech and language therapist and physiotherapist, who had fully explained care plans to them in words that they understood.

There were three case study information boards in the waiting room, which illustrated the experience of families in relation to end of life care and organ donation, to promote understanding. The unit had intentionally sponsored a third case study to ensure an example of a positive outcome was also displayed; this was a patient story of someone who had returned to a very active life after critical illness and included feedback from the person and their family.

The unit manager described how the team had engaged with a bereaved relative to gain their views to support a mortuary improvement project at the trust.
There were information leaflets and information boards for relatives in the main reception on areas such as: pressure ulcer prevention, blood transfusion, hand decontamination, infection prevention, Methicillin Resistant Staphylococcus Aureus (MRSA), CDifficile, and deep vein thrombosis (DVT). A visitor information folder gave information about the unit, including facilities on the unit, patient property, parking permits, patient diaries, hand hygiene, restaurant facilities, multi faith centre and shuttle bus information.

Is the service responsive?

**Service delivery to meet the needs of local people**

Critical care provision was flexed to meet the differing needs of level two, three and burns patients. There was an operational plan in place which outlined contingency arrangements.

The critical care outreach team (CCOT) and allied health professionals reviewed patients on the wards and provided support to patients following discharge from critical care. Information from the trust indicated there had been no occasions where the outreach team had been unavailable in the last six months, during their hours of operation.

The CCOT provided activity data which showed they had seen a total of 1013 patients in a six month period from February to July 2018. This included patients referred to the CCOT by wards and patients who had been discharged to a ward from the unit, and patients identified by CCOT while on ward visits.

Ward staff were expected to refer patients to the CCOT if they had a NEWS score of five or above, so they could be triaged and seen appropriately. The CCOT also used the electronic system to identify and offer support for patients with a NEWS score of seven or above.

Outside CCOT service hours, the bleep is held by the critical care nurse co-ordinator to receive referrals and offer telephone advice, before handing over to the CCOT the next day to follow up on progress and gauge whether further action or input is required.

The CCOT also follow up patients who had been discharged from critical care. Patients who had been receiving level 3 care and ventilated for more than four days received visits from the CCOT until the point of discharge, which staff explained aimed to meet their emotional needs as well as their physical needs.

The CCOT provided a monthly follow-up clinic, led by a senior nurse and consultant intensivist and these patients were offered an appointment on discharge from the hospital, in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standard. Physiotherapy staff had also recently started to attend the clinic to support patients with ongoing issues, for example in relation to mobility. Staff followed up patient concerns and care, for example referring to the SALT team, if any problems following a tracheostomy, for example. Staff told us most patients had an escorted visit back to the unit as part of their follow-up support and this was always offered to patients and families at the clinic.

The service had also introduced a monthly nurse-led critical care patient and relative support group, which had previously been piloted at Dewsbury. This group was open to all former patients and their visitors on a drop-in basis.

The trust had recently refurbished the overnight facilities on the unit for patients’ families. There were two well-appointed overnight relatives rooms; each room had two comfortable recliner chairs, facilities to make tea and coffee and an ensuite shower room. There was a separate large shower area with disabled access. Both rooms had television and Wi-Fi. The service had designed the rooms to incorporate ligature-proof coat hooks and safety blinds.

There was clear information for relatives about availability of hot food and vending machines. A selection of hot drinks were available in the reception / waiting area. Relatives we spoke with confirmed that they were offered the use of the overnight facilities which helped to reduce the amount of travel to and from the hospital and gave respite in often stressful situations.

The service had changed the layout of the unit, in response to feedback from relatives, to make the consulting room more private for families entering and leaving the room. Previously it had opened directly on to the reception area, which was uncomfortable for both relatives and visitors,
who may see people upset after receiving distressing news. The original room was converted into a simulation training room for staff on the unit. The service was actively involved in the regional critical care operational delivery network. There was a specific up to date business continuity plan in place for the critical care unit, which reflected the reconfiguration of services to the Pinderfields site.

**Meeting people’s individual needs**

Staff we spoke with knew how to access interpreting services for patients whose first language was not English and gave example of where this had recently been used. Patient information leaflet was available in Urdu.

Staff had a picture board they could use to aid communication with patients. Staff told us some patients could also use their mobile phones to type out a message to communicate and they could use an online translation service for day to day communication.

There was a loop system available on reception for people who used a hearing aid, although there was no sign to alert visitors. Staff told us they would contact the vulnerable adults team or senior staff for advice and support if they were working with someone with a learning disability.

Staff recognised the importance of involving relatives and carers e.g. if someone had dementia or a learning disability. Staff told us that when caring for someone with a learning disability, they would also seek support from the trust safeguarding team, which included a specialist learning disability nurse. The care we observed and the patient records that we reviewed reflected that individual needs were assessed and care planning was informed by this.

Staff we spoke with told us they could access equipment to care for bariatric patients and had not experienced delays to patient care.

A visitor’s information booklet was available in the reception / waiting area which included information about the on-site multi-faith chapel and trust chaplaincy service and menu options e.g. vegan, vegetarian and halal.

In reception, there was also an information leaflet for children visiting the unit and staff used the ‘ICU steps’ booklet for children visiting relatives in ICU.

**Access and flow**

**Bed occupancy**

From April 2017 to March 2018, The Mid Yorkshire Hospitals NHS Trust adult bed occupancy trend generally mirrored that of the England average, though the trust’ performance was better throughout the time period. In May 2017 the trust performed similar to the England average rate of 80%.

**Adult critical care Bed occupancy rates, The Mid Yorkshire Hospitals NHS Trust.**

![Graph](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
Information from the trust indicated that any patients cared for in recovery due to a critical care bed not being available would be incident reported and there were no reported incidents within the past six months.

**Delayed discharges**

**Pinderfields Hospital**

For Pinderfields Hospital, Critical Care Unit at Pinderfields Hospital, there were 5475 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 2.5%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 1.7%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>5475 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>1.7%</td>
<td>2.5%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

We were provided with the most recent ICNARC quarterly quality report. This showed that between 1 April 2017 and 30 March 2018 the bed days of care post eight hour delay rate was 2.8% this was much better than similar units which had an average of 6.4%.

We observed staff working towards timely discharge and they were aware of the need to avoid mixed sex breaches.

However, incident data showed there were patients who were not discharged to a general ward within 4 hours of the decision to do so, which was not in line with GPICS standards. For example, 68% of the incidents reported from April to June 2018 related to delayed transfers from critical care due to a suitable bed not being available within the 4 hour transfer window.

Information provided by the trust indicated that there was a process in place, for escalation to trust bed meetings and prescribed actions for staff to take, when the four hour standard cannot be achieved. Managers told us the number of delayed transfers of care from critical care were monitored by the critical care network and trends were monitored through the divisional governance report, although we did not see this in the minutes of the divisional governance meetings we reviewed.

Following inspection, the trust provided data which indicated in the 12 month period 01 July 2017 to 03 June 2018 there were a total of 61 delayed discharges over 12 hours from critical care. This is approximately five per month and equates to 6% of patients in the unit over the period (1000). Managers told us delayed discharges from critical care were reported and reviewed as part of the west Yorkshire critical care network global measures report. Data indicated no mixed sex breaches resulted from delayed discharges and the trust had one of the lowest rates of delayed discharges compared to other trusts in the region.

**Non-clinical transfers**

**Pinderfields Hospital**

ICNARC data from 1 April 2017 and 30 March 2018 showed that for Critical Care at Pinderfields Hospital, there were 740 admissions of which 0.7% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 1.4%.
Non-delayed out of hours discharges to the ward

Pinderfields Hospital

For Pinderfields Hospital, Critical Care Unit at Pinderfields Hospital, 2.4% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 2.3%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>543 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>2.3%</td>
<td>2.4%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

ICNARC data from 1 April 2017 to 31 March 2018 showed 1.7% of admissions were non-delayed, out-of-hours discharges to the ward. This was better than similar units which had an average of 2.7%.

The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient. The service had an operational policy that clearly explained the arrangements for the operational management of critical care beds within the trust.

In our previous inspection, the unit did not collect data relating to the time of the decision to admit the patient. This meant the trust could not evidence whether patients were admitted within 4 hours of the decision to admit, in line with the GPICS standards. We saw that the unit now recorded the time a patient was admitted to critical care, although a recent audit (June 2018) showed that although admission time was recorded for 95% of patients, only 19% of cases recorded the time of the decision to accept a patient onto the unit. Minutes from the divisional governance meeting indicated new documentation with a prompt to include this data was introduced and a re-audit was planned.

The patient records we reviewed showed each patient had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were two complaints about critical care, neither of which are still open. The trust took an average of 21.5 working days to investigate and close these complaints, which is in line with their complaints policy, which states complaints should be completed within 30 working days. Both complaints were related to patient care.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

At the time of inspection, there were two ongoing complaints relating to critical care. The unit manager explained however that both complaints related to patients who were stepped down from
critical care to the wards and there was concern from families about whether this was too soon. Both had been investigated and the unit manager had met with the family. We saw that identified learning was discussed at clinical and management team meetings. For example, the outreach team would now aim to better prepare and inform families of what to expect when patients were stepped down, by visiting them prior to discharge from critical care.

We saw information available for patients and families about how to contact the Patient Advice and Liaison Service (PALS) and on how to make a complaint, for example on posters and in the visitor information folder in reception and in the relatives’ overnight stay rooms.

Managers welcomed patient feedback and had recently started a log of informal comments and concerns to capture any trends. Staff told us any problems were usually resolved immediately.

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 59 compliments about critical care at Pinderfields hospital reported by the trust.

The RPIR shows 92 compliments in total, 59 for Pinderfields and 33 for Dewsbury.

*Source: Routine Provider Information Request (RPIR) – Compliments tab*

The service displayed thank you cards from patients and families in the waiting area and we saw many positive comments about the staff on the critical care unit.

**Is the service well-led?**

**Leadership**

Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. There was a lead consultant and a lead nurse (unit manager) for critical care. Management responsibilities were shared between three band seven nurses, including the outreach team lead, plus the clinical educator. The unit was led by a senior nurse as the unit manager, who reported to a matron.

There was a supernumerary coordinator on the unit and there was a team leader on each side of the unit on every shift, who would take responsibility for individual patients if needed.

From our discussions with the unit manager, it was clear they had an understanding of the current challenges and pressures impacting on service delivery, patient care and staff morale e.g. The unit manager was aware of the impact of moving staff to other wards and the need to support staff who were engaged in teaching and mentoring new team members.

Since the service reconfiguration, there had been a focus on recruitment and training for staff new to the unit. An international recruitment programme was at an advanced stage, with nurses due to join the team towards the end of 2018. The unit had also been successful in attracting staff by holding several specific open days on the unit. There was work in progress to recruit to two band six development posts and the education team had grown since the last inspection.

There were plans in place to address gaps and areas of non-compliance with GPICS standards identified in the peer review report (Dec 2017) and this was summarised in the draft critical care strategy and action plan.

We saw from board papers that members of the trust executive team completed walk-rounds of critical care, twice in the past 12 months (December 2017 and March 2018). Senior and front-line staff reported the leadership team and senior staff were visible and approachable. Staff told us they felt very supported by their teams, confident in their managers and able to escalate any concerns. Following closure of the Dewsbury critical care unit in September 2017 some critical care staff transferred and relocated to the Pinderfields site. We spoke with staff who had transferred at this time and they spoke highly of the leadership approach, innovative practice, learning culture and ethics.
Senior managers told us were very proud of all the staff and the quality of the care they provided for their patients and families and acknowledged that the critical care leadership team had worked hard to complete the service reconfiguration and manage associated recruitment challenges, to stabilise the service, in recent months. They described the next steps were to ensure critical care was well-represented at other trust-wide meetings and to further develop relationships with other medical specialties.

**Vision and strategy**

The operational policy set out the vision for the unit; ‘Provide the highest possible standard of care for Level 3 and Level 2 critically ill patients within the unit and support Level 1 patients by integration with the general wards through the Critical Care Outreach service.’

At the time of inspection, the leadership team were engaged in the development of a new critical care specific strategy for 2018-2020. We reviewed the draft strategy and saw it set out a vision and philosophy which was patient and relative focussed, for example, acknowledging that the team delivers a service to people who are experiencing ‘trying times’, the importance of listening to the public and MDT working.

The draft strategy included a scorecard of performance against GPICS and a plan to achieve compliance. It set out the six trust strategic objectives and linked these to the current position and the priorities for critical care. The action plan set out actions to move towards GPICS compliance for each year, using the areas for improvement identified from the peer review in December 2017, including; post-registration training for staff, microbiology input, timely admission and discharge and the main ventilation system. We did not see mention of the outreach service in the draft e.g. the vision to provide a 24 hour outreach service. However, the strategy and action plan was still in development and managers had recently shared the draft document with nursing and medical staff for their feedback.

The leadership team told us a business case was in progress to secure dedicated psychology input for the critical care unit, to proactively support both patients and staff. This type of input was infrequently available in similar services. Clinical staff had recognised a need for more structured assessment of psychological need and a patient questionnaire was being used to collect data to support the business case.

The service had begun planning for service continuity while work was undertaken to resolve the ventilation issue. This work was intended to begin in 2019.

**Culture**

Staff we spoke with told us they felt able to raise concerns and were aware of the importance of being honest and open. They were able to explain the duty of candour and the need to apologise to patients and relatives in line with trust policy if there had been a mistake.

Medical staff told us teamwork and communication between consultants had improved significantly since the reconfiguration as the team were located together on a single site. They had also developed a closed instant messaging group to facilitate daily communication.

We observed a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable, encouraged teaching and learning and valued each other’s opinions.

Reception staff told us they felt valued as part of the team and were invited to staff meetings.

The unit manager recognised that nursing staff morale was affected by the movement of staff from the unit to cover staffing vacancies on the wards. Incident data showed any problems with timely return of critical care staff to the unit were reported. Managers explained this was monitored and a process had been put in place to ensure staff who moved had appropriate responsibilities on the wards. Staff understood the reasons for being moved and felt supported by the senior staff in critical care who managed this fairly. Managers showed us two examples of positive feedback from wards where critical care staff had been moved to, which had been shared with the team.
Governance

The service was managed by the anaesthetic clinical service, part of the division of surgery. Monthly anaesthetics clinical governance meetings took place.

At the previous inspection, there were concerns that the service did not have a forum for senior clinical staff to discuss operational and quality issues. At this inspection, we found that monthly critical care unit management meetings took place. Managers explained the agenda had recently been reviewed, to better reflect the unit’s purpose as a business meeting. Previously each meeting had alternated between operational and governance issues. We reviewed two sets of minutes and we found that senior clinical staff attended to discuss a range of items related to risk, incidents, audits, medicines and policy updates.

A new standing agenda had recently been introduced to ensure discussion of both business and clinical governance items at on a monthly basis, including ICNARC and global measures data. We found that although data from the Intensive Care National Audit and Research Centre was available on the staff notice board, it was not discussed with the wider staff team or systematically reviewed at the management team meeting.

Managers had identified that staff attendance had been poor and there was a need to ensure communication to the wider staff group from the new style business meetings. They were in the process of identifying staff representatives from different grades and professions who would be expected to attend the monthly business meetings and feed back key messages to their staff groups. Reception staff said they were invited to ward meetings, every 3 months. The minutes we reviewed indicated meetings had not been regularly attended by frontline staff.

Daily safety huddles took place following handover and staff told us they felt they were a good way of sharing information. Patient information was shared with staff and between clinical co-ordinators during the hand over process. We observed a clinical handover given by the lead clinical coordinator leaving shift to the clinical coordinator of each side of the unit and saw this included information about staffing, staff sickness, expected admissions, equipment faults, key handover, regional critical care bed availability, diary bookings, and potential patient step downs from critical care. We observed a handover to the incoming staff nurses from one of the co-ordinators; each patient was discussed in detail including; diagnosis, plan of care, nursing care and relative support. We saw that each nurse then received a detailed handover for each patient at the bed space from the nurse caring for that patient.

Although managers told us the service did not have a specific audit lead or strategy, we were provided with an audit plan following inspection, which included named responsible leads and frequency of regular audits completed. We saw that audits were on the new structured standing agenda for the managers business meetings.

We reviewed the West Yorkshire Critical Care Operational Delivery Network peer review report dated January 2017. This included a green RAG rating in relation to National Institute for Health and Care Excellence (NICE) CG83: rehabilitation after critical illness. Managers had identified an action plan based on the recommendations from the report, which was incorporated into the draft strategy.

Management of risk, issues and performance

There was a divisional risk register and a risk register for critical care. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. Examples on the unit’s risk register included staff recruitment; specialist skills and staffing numbers and the pressure.

At the previous inspection, areas of non-compliance with GPICS were not recorded on the risk register, some risks and controls were overdue for review and the risk register was not formally reviewed. Before inspection, we reviewed the critical care risk register and found some of the risks were overdue for review. However; during inspection, managers were able to show us that actions had been updated on the electronic system, with progress to manage each risk updated within the last 3 months, with dates set for the next review. However, a formal review of the risk
register was not yet embedded into management team meetings. Senior staff told us the risk register would be reviewed as part of the new monthly business meeting standing agenda. We also saw that GPICS non-compliance were recognised and included in the risk register, for example post registration training and microbiology input. There was also a risk relating to grade 2 pressure ulcers, which had been identified from incident data. Management meeting minutes showed patient care was prioritised over cost, for example where ICU beds required agency staff to maintain sufficient capacity, this was supported to ensure patients were not at risk.

There was a nominated sepsis lead for the trust. The outreach team carried out an audit of the use and response to NEWS scores, including timeliness of observations, across the trust and performance information was monitored across the trust.

The service benchmarked itself with other services and against best practice in the West Yorkshire network and actions from the peer review were linked to the draft critical care strategy and action plan. The peer review (Dec 2017) noted the service reconfiguration had had a positive impact and compliance against GPICS standards and although there remained areas of non-compliance, the unit had improved in a number of areas including medical staffing and nurse staffing. An action plan had been developed which was incorporated into the new draft critical care strategy.

At the last inspection, we found the critical care outreach team (CCOT) did not report formally their activity or performance outcomes to the senior management team. During this inspection we saw that the CCOT carried out a detailed audit of NEWS scores and performance across the trust against trust targets, which was reported to senior managers. The outreach team were able to provide activity data on the numbers of patients seen who were referred by the wards, identified by the CCOT or seen at follow-up clinics, however it was unclear whether there were identified performance outcomes or targets for the CCOT team itself and how the activity data was monitored and used for service improvement.

**Information management**

Blood results, x-rays and scan results could be accessed electronically. Staff accessed trust policies electronically using the intranet and updates or changes were discussed at handovers and in management team meetings.

Staff received training on governance and were aware of the importance of managing patient information. On inspection we found that records were stored securely within the unit.

**Engagement**

The service engaged patients and families to plan and improve services. For example, the service had relocated the consulting room to offer more privacy to families for confidential and difficult conversations, in response to feedback. The service had worked with a family to develop ‘care packs’ for relatives unexpectedly staying overnight and had engaged with two bereaved families to input into an end of life improvement project.

Staff in the critical care outreach team shared feedback from patients and relatives who attended the follow up clinic with staff on the unit and with the trust patient experience group, to help improve the service.

There was a suggestion box and leaflets for patient and visitor feedback at the reception area. Information was displayed on ‘you said’ ‘we did’ in response to patient feedback. The most recent example was in response to an identified theme around visitors feeling uncomfortable observing relatives entering the consultant office from the reception area and seeing people leave this office, upset after receiving distressing news. The office was relocated in a private area offering privacy and dignity to relatives/carers.

Staff we spoke with told us communication on the unit was good, for example they received information about a recent change in practice regarding resuscitation trolleys by email, at handover and it was discussed at the monthly team meeting.
The unit held staff meetings every two to three months. We reviewed the minutes from the meeting and saw evidence that incidents, infection control, education and movement of staff to the wards were examples of topics discussed, although it was mainly senior staff who attended.

We saw that the staff information board shared relevant and up to date information including meeting minutes, education and appraisals information and that there was also a board describing what the team were proud of. This included teamwork, outreach team and joint working, recruitment and high-quality care. Staff were encouraged to participate. Comments stated that the team were proud of positive patient feedback, one staff member stated that she was proud to be part of a dynamic outreach team, great atmosphere on the unit and well supported by senior staff. We saw that the unit manager had used focus groups and suggestion boards to pro-actively gather practical suggestions from staff on how to welcome new international nurses who were due to join the trust later in the year. Staff had also been sent a copy of the critical care draft strategy, for them to give feedback.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network. The service had one advanced critical care practitioner and two trainees.

The unit was involved in anaesthetic research and had a critical care research nurse currently contributing to a regional allergy study.

Senior nurses in critical care were developing specific end of life training for critical care staff, working with the palliative care team.

Senior medical staff were developing a policy for decision-making around patients with devastating brain injury.

Managers were developing a business case to secure dedicated psychology input for the unit.

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**Maternity**

### Facts and data about this service

The Mid Yorkshire Hospitals NHS Trust provides maternity services over three hospital sites. Following a service re-design in September 2016, all inpatient and obstetric led maternity services were amalgamated on the Pinderfields Hospital site. There are two stand-alone midwifery led birth centres, one at Pontefract Hospital and one at Dewsbury and District Hospital. There is also an alongside birth centre at Pinderfields Hospital.

The Mid Yorkshire Hospital NHS trust has 79 maternity beds across three sites. 71 beds are located within eight wards at Pinderfields Hospital.

Maternity services at Pinderfields Hospital include early pregnancy assessments, an antenatal day unit, and antenatal and postnatal outpatient clinics. There is a separate maternity triage unit available to provide assessment and reassurance for women with antenatal concerns.

The 13-bed delivery suite provides care for both high risk women and low risk women who choose to deliver there. Antenatal and postnatal inpatient care are offered at the site; and includes specialist care for women who need closer monitoring and high dependency care. There is also an enhanced recovery area, where women who are booked for an elective caesarean section are admitted to; and in many cases, receive their full care from admission to discharge.

Pinderfields birth centre is an alongside midwifery-led unit, opened in September 2016. The birth centre provides care for lower risk women wanting to deliver there. The birth centre includes six
birthing rooms; of which two include a birthing pool. All six rooms are appropriate for antenatal, intrapartum and postnatal care.

From January 2017 to December 2017 there were 5,925 deliveries at the trust. A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

**Number of babies delivered at The Mid Yorkshire Hospitals NHS Trust – Comparison with other trusts in England**
A profile of all deliveries from January 2017 to December 2017 can be seen in the tables below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MID YORKSHIRE HOSPITALS NHS TRUST</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
</tr>
<tr>
<td><strong>Deliveries (n)</strong></td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Multiple</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
</tr>
<tr>
<td>Under 20</td>
</tr>
<tr>
<td>20-34</td>
</tr>
<tr>
<td>35-39</td>
</tr>
<tr>
<td>40+</td>
</tr>
</tbody>
</table>

**Total number of deliveries**

| Total | 5,925 | 593,637 |

*Source: Hospital Episode Statistics*

*Notes: A single birth includes any delivery where there is no indication of a multiple birth.*

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the chart below.

**Number of deliveries at The Mid Yorkshire Hospitals NHS Trust by quarter**

![](chart.png)

*Source: HES - Deliveries (January 2017 - December 2017)*

From July 2017 to June 2018, there were 6,365 deliveries at the trust. Of these, 5,748 deliveries were at Pinderfields District Hospital. There were 4,856 deliveries at Pinderfields hospital labour suite, and 892 deliveries at Pinderfields birth centre; the alongside midwifery-led unit. During the period, there were 44 planned home deliveries at the trust and 68 unplanned home deliveries or babies born before arrival.
Is the service safe?

Mandatory training

All attendance at training provided by the service was monitored by the midwifery clinical educator and matrons. Staff were automatically rostered to attend mandatory training. We were told that non-attendance at mandatory training was treated seriously and escalated to the matrons and Interim Head of Midwifery (IHOM), as required.

Mandatory training completion rates

The trust set a target of 95% for completion of level 1 (core) mandatory training, and 85% for level 2 (role specific) mandatory training.

Trust level

Breakdowns of compliance for mandatory training courses for all applicable staff in maternity services at the trust as of June 2018 were provided.

The table below shows core training course compliance for all staff within the service, against a trust target of 95%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity Awareness</td>
<td>449</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 1</td>
<td>439</td>
<td>450</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety Level 1</td>
<td>430</td>
<td>450</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>422</td>
<td>450</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>387</td>
<td>450</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>377</td>
<td>450</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Overall total</td>
<td>2504</td>
<td>2700</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Overall, 93% compliance was achieved for the core mandatory training courses shown above; just below the trust target of 95%.

The trust target was met for three of the six mandatory training courses; a fourth (infection control) fell slightly short of target (94%). Compliance was not achieved against trust target for information governance (86%) and fire safety (84%) training courses.
The table below shows core training course compliance for applicable (role specific) staff within the service, against a trust target of 85%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management Level 2</td>
<td>266</td>
<td>275</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>398</td>
<td>419</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation Training</td>
<td>358</td>
<td>394</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 2</td>
<td>305</td>
<td>357</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>348</td>
<td>423</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety Level 2</td>
<td>298</td>
<td>395</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td><strong>1994</strong></td>
<td><strong>2285</strong></td>
<td><strong>87%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Overall, 87% compliance was achieved for the role specific mandatory training courses shown above, surpassing the trust target of 85%.

The trust target was met for five of the seven mandatory training courses; a sixth (patient safety) fell slightly short of target (82%). Compliance was not achieved against trust target for health and safety level 2 training (75%).

Mandatory training for staff working in maternity services should include neonatal and obstetric emergencies training as a minimum (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

Midwives, health care assistants (HCA) and medical staff attended a one-day Yorkshire Maternity Emergency Training (YMET) obstetric mandatory programme; which included obstetric emergencies, mandatory skills and drills, deteriorating patient, sepsis, and human factors training. Managers expected staff to attend the annual YMET as a priority.

The service provided trust-wide data for the maternity workforce that showed 95% of all applicable staff (356 of 375) had completed YMET training as of the end of June 2018. Data was provided for staff groups, which showed 96% of qualified midwives and nurses, 92% of maternity support workers and assistants, and 92% of maternity services medical staff had completed the training.

At our previous inspection in May 2017, we found some staff reported they had not taken part in skills and drills training on the labour ward and birth centre. At this inspection, all staff we spoke with said they had been involved in regular skills and drills training.

In addition to annual skills and drills (YMET) training, staff told us that regular ad-hoc skills and drills training took place at the birth centre. Previous ad-hoc skills and drills training had included responding to post-partum haemorrhage, cord prolapse, eclampsia, shoulder dystocia, and vaginal breech scenarios.

Senior management told us that to enhance learning from obstetric emergencies, senior staff attended ‘real life’ emergencies in an observational capacity on the labour ward. They then provided formal feedback about communication, leadership, and teamwork for the full
multidisciplinary team involved. We observed evidence of this in the 2 July 2018 multidisciplinary safety brief.

We reviewed data provided by the trust, which showed 99.5% of qualified midwives and nurses across at trust-level (241 of 242) had completed fetal (CTG) monitoring training.

The trust informed us that they had recently started providing voluntary third and fourth degree tear training to maternity services staff. We reviewed a training agenda and saw the programme began in 2017 and had 24 attendees over the first two courses. A further teaching session was planned for October 2018. Senior staff told us they expected more attendees over the next 12 months, now that the study days funded by Health Education England had been completed.

The Women’s and children’s group action plan (2017) detailed that neonatal resuscitation training was to be provided to all maternity service staff as mandatory training, with an implementation date of August 2018.

**Safeguarding**

**Safeguarding training completion rates**

**Trust level**

The trust set a target of 95% for completion of level 1 (core) safeguarding mandatory training, and 85% for level 2 and level 3 (role specific) safeguarding mandatory training.

A breakdown of compliance for safeguarding mandatory safeguarding training courses for applicable staff in maternity services at the trust as of June 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (L1)</td>
<td>448</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (L2)</td>
<td>183</td>
<td>195</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (L3)</td>
<td>190</td>
<td>205</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (L1)</td>
<td>443</td>
<td>450</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (L2)</td>
<td>351</td>
<td>399</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met completion targets for all five safeguarding training modules for which maternity services staff were eligible.

Midwives received annual safeguarding level three training in line with the intercollegiate guidelines. As of June 2018, records showed 93% of midwives had completed this training against a trust target 85%.

There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children. The safeguarding midwife was integrated into the safeguarding team.

There was a safeguarding integrated care pathway in use across maternity services at the trust that utilised an established vulnerability assessment tool. It provided a contemporaneous record of care, contacts and conversations that the midwife had with the mother and other professionals,
with the information transferred to the records of the new baby. ‘Flags’ were used in patient care records and on electronic systems to alert staff to safeguarding concerns.

Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. Staff told us they were happy to contact the safeguarding team for advice and support if required. Staff also said that there was a local authority domestic violence group that could be accessed for information and advice.

From April 2018 to March 2018, 296 child safeguarding referrals and 23 adult safeguarding referrals were made by maternity services staff at the trust.

The trust had a Female Genital Mutilation (FGM) policy in place (July 2017). The policy requires practitioners to complete an incident form for every case of FGM or suspected FGM that is identified during the delivery of healthcare within the trust. The Safeguarding Team were alerted to the incident report via the incident reporting system. Training on FGM was delivered through the trust safeguarding training.

There was a video call entry system onto the unit with a green push button exit. All paths out of the unit were in full view of manned reception desks. There was no infant alarm system in place; however, staff told us babies stayed with mothers or in the presence of a visitor (for example, family member) at all times. When mothers and babies transferred between wards staff undertook a formal handover using the situation, background, assessment and recommendation (SBAR) tool, this included checking the baby identification bracelets.

**Cleanliness, infection control and hygiene**

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks with hand washing technique signs. Hand gels were located at entrances with signs encouraging their use, and throughout clinical areas.

We saw staff washing their hands and using hand gel between patients, as appropriate. All staff we met adhered to arms bare below elbows guidance.

Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

Clinical areas were visually clean, and the cleaning schedules we reviewed were fully completed. We saw infection, prevention and control flowcharts displayed that showed cleaning procedures for different environments and equipment. Infection prevention and control information posters and leaflets were displayed in the areas visited.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services at the trust in the last 12 months. Single rooms were available for the isolation of patients, if needed.

In the 2017 CQC maternity survey, the trust scored 9.0 out of a possible 10 for the cleanliness of rooms and wards; this was similar to the England average.

The service conducted monthly infection, prevention and control audits. June 2018 data showed overall compliance (across 12 individual measures) ranged from 93% to 99% at the location.

In March 2018, routine water sampling had identified potential legionella bacteria in one of the pool rooms at the alongside midwifery-led birth centre. This had been added to the maternity risk register as presenting a moderate risk. We saw that the risk had been appropriately managed. The pool had been closed, sanitised, and regularly screened; with no further concerns raised. We observed a daily pool checklist (including flushing) had been completed for the period reviewed.
and monitoring was ongoing. An investigation found the initial finding was probably due to sampling error. The risk was removed from the register in July 2018.

Staff told us they had raised concerns about the quality and integrity of the floor in the birth centre and triage area. Minor damage was noted in all areas. This effected cleaning, posing an infection risk to staff and patients. This had been added to maternity risk register in September 2017, and rated as high. Staff told us that mitigating actions included bi-monthly reviews by the infection prevention and control nurse; and visits and findings were recorded on the infection, prevention and control master log. Risk register data (June 2018) showed that concerns about the floor had been escalated to the director of operations for further escalation. Following our inspection, the trust informed us that the floor remained on the maternity service risk register and the trust IPC risk register. The floor had been identified on the Estates Capital 10 Year Plan, but needed to be risk assessed against other competing risks for funding to replace it. The action currently sat with the estates department to replace the flooring, once funding had been identified.

We observed three surgical procedures during the inspection and saw staff followed correct ‘scrubbing in’ and preparation protocols.

The service had introduced new infection prevention control procedures for caesarean sections, following NICE sepsis guidelines (2016). Input from plastic surgery colleagues had been obtained and a new theatre competency document developed. This included improved cleaning regimes, preparation of the site for surgery, and a ‘red line’ exclusion zone for procedures. An audit conducted in June 2018 showed the incidence of deep surgical site infection had been reduced from 40% to 5%. A re-audit was planned for November 2018.

Environment and equipment

Maternity services at Pinderfields Hospital included early pregnancy assessments, antenatal and postnatal outpatient clinics, and an antenatal day unit. The early pregnancy assessment unit (EPAU) was housed alongside the gynaecology assessment unit (GAU); there was one scan room, three clinic rooms and an assessment room. There was a waiting area adjacent to the reception desk, which enabled staff to observe women who were waiting. The antenatal day unit had five couches and chairs, divided by curtains.

There were 71 maternity beds located within 5 ward areas (birth centre, triage, post anaesthetic care, delivery suite and ante/post-natal ward).

There was a 5-bed maternity triage unit available to provide assessment and reassurance for women with antenatal concerns. The service had recently added a pre-admission assessment room, to try and positively influence delays and assist with timely prioritisation. The waiting area for the triage unit was in the corridor just before the doors to the unit. As found at previous inspection in May 2017, during our current inspection, staff recognised this was not ideal but the service was tied to the physical footprint of the building. Staff could observe this waiting area using closed circuit television surveillance (CCTV). There were no signs to advise those waiting what to do in an emergency; however, staff said they explained to women what they should do if they felt unwell or their condition deteriorated. Staff told us that plans were being developed to move the double doors separating the triage from the waiting area to the end of the corridor, to incorporate the waiting area into the clinic.

The 13-bed labour ward provided care for both high risk women and low risk women who chose to deliver there. One room had a birthing pool and telemetry CTG monitoring. This meant that high-risk women would be able to labour in the pool. The labour ward had three theatres, one for elective and two for emergency caesarean sections. There was a four-bedded enhanced recovery bay for women following elective caesarean, and a four-bedded recovery bay for women following emergency caesarean, and two high dependency beds.
Antenatal and postnatal inpatient care was offered at the site; and included specialist care for women who need closer monitoring. Wards contained a mixture of individual ensuite rooms, side rooms, and bays. There was a five-bedded transitional care unit, which allowed specialist care to be given to higher dependency babies that were well enough to be looked after alongside their mother.

Pinderfields birth centre was located adjacent to the maternity triage area and provided care for lower risk women wanting to deliver there. If needed, the labour ward could be accessed via the interjoining post anaesthetic care unit (PACU) in an emergency. The six-bedded birth centre included two birthing pool rooms, and two postnatal rooms.

The birthing pool room in the labour ward had an electronic ceiling hoist, which could be used to evacuate the pool in an emergency. Birthing pool rooms at the birth centre had pool nets available to evacuate the pool in an emergency. Staff we spoke with told us that they had participated in a pool evacuation drills as part of their skills and drills training.

There was adequate equipment on the wards to ensure safe care – specifically, cardiotocography (CTG), resuscitation equipment and directional lights. Staff confirmed they had sufficient equipment to meet patient needs and appropriate training to use it.

The clinical equipment checked was found to have in date electrical testing labels.

We reviewed a variety of emergency and essential equipment across the maternity service. This included adult resuscitation trollies, emergency drug boxes, resuscitaires, emergency trolley box, sepsis box, post-partum haemorrhage (PPH) eclampsia and cord prolapse emergency trolleys. During the inspection, we found all checks on emergency and essential equipment were complete.

A wheelchair and transfer trolley (stored on the PACU) were available for women who required transfer.

There was adequate equipment in the labour ward and the birth centre to meet patients’ needs. This included a variety of equipment for women to use in labour; for example, birthing balls, birthing stools, birthing couches, and TENS machines.

Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation across clinical areas. The utility and stock rooms we inspected were clean and well organised.

Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use. Labels were available and used appropriately.

**Assessing and responding to patient risk**

The service had escalation policies and guidance in relation to a deteriorating woman or baby. These included a clinical practice care pathway for early recognition of severely ill pregnant women (review date, April 2020), transfer of a sick new born to neonatal services (review date, September 2019). There was also guidance on physiological observation of women in maternity (review date, May 2020), a maternity services new born resuscitation policy (review date, February 2020), and a standard operating procedure for paediatric attendance at birth (review date, June 2019).

There were robust midwifery led care policies, which identified the criteria for women being able to deliver at the alongside birth centre (review date, June 2019) and at home (review date, January 2020). We reviewed the birth centre guidelines and found comprehensive guidance about admittance criteria and risk factors, review and monitoring of higher risk (outside of criteria) women, multidisciplinary care planning, admission and assessment, labour and birth, management of obstetric emergencies, and transfer procedures.
The unit used the ‘fresh eyes’ approach, which indicated a proactive approach in the management of obstetric risks. We reviewed three patient records that contained fresh eyes tools and found ‘fresh eyes’ had been fully documented in two of the three applicable records reviewed.

Following our inspection, the trust informed us that use and documentation of ‘fresh eyes’ was captured in the clinical record keeping audit. We reviewed the ‘clinical audit programme and action plan obstetric/midwifery update’ (July 2018) and saw the audit (Biannual Reporting: 617) was estimated to commence April 2017, and estimated to be completed by June 2018. However, following our inspection, the trust informed us that results were not yet available. Therefore, we were unable to comment on the use and documentation of ‘fresh eyes’ in the wider service. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). Therefore, we were unable to comment on the use and documentation of ‘fresh eyes’ in the wider service.

Midwifery staff identified women showing signs of early deterioration by using an early warning assessment tool known as the Modified Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed five records that contained MEWS tools and saw all were appropriately completed.

The service confirmed that they had not completed a MEWS audit in the 12 months prior to our inspection, to ensure compliance with monitoring and escalation of deteriorating patients. However, we did see evidence that MEWS was included within the scope of the 2017-18 annual record keeping audit, and the service continued to implement and embed recommendations and learning from the 2016 audit. Following the inspection, the trust provided us with provisional findings from the 2018 MEWS Audit (completed August 2018), that had been ongoing at the time of inspection. As these had not been quality assured we do not present them here. The trust informed us that once data analysis was finalised, a full audit report would be completed which will include an action plan to address the improvement requirements identified.

At our previous inspection in May 2017, we found some staff reported they had not taken part in skills and drills training on the labour suite and birth centre. At this inspection, all staff we spoke with said they had been involved in regular skills and drills training. In addition, senior staff attended ‘real life’ emergencies in an observational capacity on the labour ward, and provided formal feedback for the full multidisciplinary team involved. The birth centre manager reported there had been no problems summoning staff from triage during skills and drills training.

There was an entry on the maternity risk register from November 2017 that showed the emergency bell on the birth centre was not heard outside the birth centre area. In addition, that the emergency bell was difficult to hear over the activity of the birth centre. We spoke to the birth centre manager who said that the volume of the emergency bell had been increased since the issue had been raised. They told us that if there was an emergency, staff would immediately call the crash team; this was confirmed by staff and evidenced on emergency flow charts displayed in the birth centre. The manager explained that plans were in progress to add an additional emergency bell in the birth centre office. We saw that a works form had been submitted for the emergency call bell to ring in the triage area and birth centre office, and for an additional alarm to be added on the birth centre next to the resuscitaire.
Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in theatres of a World Health Organisation (WHO) surgical safety checklist. The service did not use the maternity specific WHO checklist but had developed their own version of the checklist. Staff we spoke with were aware of this document.

At our last inspection of the service in May 2017, we found that safe surgical checklists were not being fully completed by medical and theatre staff.

During our recent inspection, we directly observed correct use and completion of the surgical safety checklist on three separate occasions. We reviewed an additional four surgical safety checklists in patient files and found three were fully completed. In one of the checklists, the signing out section had not been fully completed (the signature was missing).

The Clinical Audit Programme and Action Plan Obstetrics/Midwifery Update (July 2018) showed a Perioperative Care Pathway WHO Safe Surgery audit was due to commence March 2017, with an estimated finish date of December 2017. However, the July 2018 update detailed that this was still ongoing. Following our inspection, the trust informed us that the WHO checklist audit was due to be completed December 2018. Therefore, we were unable to comment on the use and documentation of safer surgery checklists in the wider service.

During our recent inspection, we observed good swab counting practices in the surgeries inspected. However, this could not be evidenced by audit results. The Clinical Audit Programme and Action Plan Obstetrics/Midwifery Update (July 2018), did not show that a ‘swab count’ audit had been conducted in 2017 to 2018. A ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. Therefore, we were unable to comment on the use and documentation of ‘swab counts’ in the wider service.

Data provided by the trust showed 91% of applicable maternity services staff had received resuscitation training as of June 2018. The Women’s and children’s group action plan (2017) detailed that neonatal resuscitation training was to be provided to all maternity service staff as mandatory training, with an implementation date of August 2018.

There was a paediatric tier one on call for labour ward at all times. They could be contacted on the hospital bleep system, numbers were recorded on the staffing boards in clinical areas, and they were available via switch board. In an emergency the paediatric resuscitation team could be summoned by calling 2222.

There were processes in place in the event of maternal/baby transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.

Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

**Midwifery and nurse staffing**

The service used Birthrate Plus to enable a comprehensive review of midwifery staffing numbers based on the different models of care. A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the current funded establishment of 222.87 midwives was correct for the activity in the maternity service; and took into account women that may birth in other units but whom required antenatal and postnatal care from the maternity service.

Most midwives at the service were employed as ‘rotational midwives’. Staff worked within their preferred area of work forming a ‘core’ element, but they could be redeployed to work on other
wards/department within the service at short notice. For example, to cover unplanned sickness or to cover planned sickness or annual leave on other departments.

Staffing establishment on the labour ward was comprised of two coordinators, eight registered midwives, a scrub nurse and three healthcare assistants.

The service had registered nurses as part of the theatre and high dependency teams; who supported midwifery colleagues.

Birth centre establishment staffing included two midwives and one healthcare assistant. On-call cover for the birth centre was provided by the community midwifery team.

Establishment on the triage unit included two registered midwives and one healthcare assistant.

At our last inspection, the birth centre and triage had a ‘floating’ (extra) midwife on every shift that would be the nominated to go to labour ward if needed. At this inspection, we found that the role had been assessed and no longer existed. The birth centre and triage was managed by a band seven midwife. Both areas now had established core teams of qualified midwives and midwifery care assistants (MCA); and the birth centre utilised rotational staff and on-call community midwives, if needed.

The service had an escalation policy (review date August 2019). The policy provided guidance for maternity staff about clinical decision making and required actions in the event of a situation where capacity and complexity of workload presented challenges in the delivery of a safe maternity service for women and their babies.

Labour ward coordinators and the senior midwife assessed workload and staffing across the service and bed capacity within the maternity units at the start of each shift (8am and 8pm); by liaising with the ward manager/ shift leader from ward 18 and birth centres. Staff told us that four hourly data entry sheets were completed to monitor staffing. These were reviewed by maternity matrons and submitted to the patient flow manager to ensure effective management of staffing shortfalls.

Labour ward coordinators and the senior midwife assessed the Operational Pressures Escalation Level (OPEL) score of the service, documented this on the data entry sheet and reported this to the morning bed meeting via the bed report during the working week.

In the event of escalation, the labour ward could redeploy midwifery staff from across the service. Labour ward coordinators remained supernumerary throughout escalation processes, and were required to liaise with all maternity service areas to establish whole unit workload. They also had to make the midwifery advisor on call aware of activity levels.

The alongside birth centre manager / matron was able to call on labour ward midwives (if available, following permission from the labour ward coordinator). If unavailable, other birth centre midwives and community midwives could be called on for assistance (after consultation with the midwifery advisor on call).

The trust did not provide us with midwifery and nurse staffing information for individual locations. Therefore, the data below is presented for maternity services at trust-level. The one exception to this is bank and agency staff use, for which location level information is presented.

We also note, that despite good overall trust-level maternity staffing figures, we were concerned that staff were not allocated properly across the service to meet service need. This is explained in more detail in the Responsive (access and flow) section of the report.

Planned vs actual

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the current funded establishment of 222.87 midwives was correct for the activity in the maternity service. During our
inspection, senior staff told us that 217 WTE midwives were contracted within the service. This equated to a nursing and midwifery staffing fill rate of 97.4% within maternity services at the trust.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 1.0% in maternity services, meeting the trust’s 9% target.

During this period, there was a 3.6% vacancy rate among community midwives at the trust, and a -2.6% vacancy rate among maternity ward midwives at the trust (the negative figure means that maternity ward midwives were staffed over establishment level).

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

During our inspection, senior staff told us that the service had funding for 228.87 WTE midwives, and 217 WTE midwives were contracted. This meant there was 11.87 WTE vacancies at trust level. This equated to a vacancy rate of 5.19%, which met the trust’s 9% target.

Senior staff described they had gained permission to overrecruit midwifery staff, and there was a rolling programme of recruitment. They told us that 9.2 newly qualified WTE midwives had been appointed in June 2018; and were scheduled to commence employment October 2018. They also advised us that they would be advertising for additional posts shortly, as part of their rolling programme of recruitment.

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 13.4% in maternity;

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff leavers</th>
<th>Average WTE establishment</th>
<th>Turnover rate</th>
<th>12% Target met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; midwifery staff (Qualified nurses)</td>
<td>28.0</td>
<td>215.1</td>
<td>13.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>2.0</td>
<td>8.3</td>
<td>24.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>30.0</td>
<td>223.4</td>
<td>13.4%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the 12% turnover target for qualified nursing or midwifery staff.

During this period, there was an 11.3% turnover rate among community midwives at the trust, and a 14.3% turnover rate among maternity ward midwives at the trust.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Senior staff told us that the turnover rate had improved in the latter half of the reporting period described above. They attributed higher rates of turnover earlier in the reporting period to post-reconfiguration of services. The trust provided data that showed from October 2017 to March 2018, the midwifery turnover rate was 5.31% (14 leavers). This was within the trust target of 12%. The service attributed current trends in staff turnover to both the retirement of staff and the transient nature of newly qualified midwives. The service was undertaking an age profile review of the midwifery workforce to inform future workforce and succession planning.
**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 6.3% for qualified nursing and midwife staff in maternity services.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff sick days</th>
<th>Staff days</th>
<th>Sickness rate</th>
<th>4.8% Target Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>4,959.6</td>
<td>79,088.5</td>
<td>6.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>189.8</td>
<td>2,645.1</td>
<td>7.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>5,149.4</td>
<td>81,733.6</td>
<td>6.3%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the sickness rate target of 4.8% for qualified nursing or midwifery staff.

During this period, there was a 7.5% sickness rate among community midwives at the trust, and a 5.5% sickness rate among maternity ward midwives at the trust.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017 - March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the sickness rate among midwifery staff was marginally above trust target of 6.3%, and stood at 6.76%. However, the sickness rate was improving.

During our inspection, senior staff told us that the sickness rate among midwives had improved, and in June 2018 stood at 4.6%; which was within trust target. In addition, the sickness rate for community midwives had been reduced to 5.1%.

**Bank and agency staff usage**

The table below shows the total number and proportion of shifts filled by qualified bank midwifery staff from April 2017 to March 2018 in maternity services at the location:

<table>
<thead>
<tr>
<th>Unit/area</th>
<th>Total shifts</th>
<th>Number filled by bank staff</th>
<th>Proportion filled by bank staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate 18</td>
<td>4438</td>
<td>191</td>
<td>4.3%</td>
</tr>
<tr>
<td>Gate 18a, Labour ward</td>
<td>11011</td>
<td>349</td>
<td>3.2%</td>
</tr>
<tr>
<td>Pinderfields Birth Centre</td>
<td>2705</td>
<td>58</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18154</strong></td>
<td><strong>598</strong></td>
<td><strong>3.3%</strong></td>
</tr>
</tbody>
</table>
The table below shows the total number and proportion of shifts filled by qualified agency midwifery staff from April 2017 to March 2018 in maternity at the location:

<table>
<thead>
<tr>
<th>Unit/area</th>
<th>Total shifts</th>
<th>Number filled by agency staff</th>
<th>Proportion filled by agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate 18</td>
<td>4438</td>
<td>208</td>
<td>4.7%</td>
</tr>
<tr>
<td>Gate 18a, Labour ward</td>
<td>11011</td>
<td>363</td>
<td>3.3%</td>
</tr>
<tr>
<td>Pinderfields Birth Centre</td>
<td>2705</td>
<td>34</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18154</strong></td>
<td><strong>605</strong></td>
<td><strong>3.3%</strong></td>
</tr>
</tbody>
</table>

The table below shows the total number and proportion of shifts filled by qualified agency and bank midwifery staff (combined) from April 2017 to March 2018 in maternity at the location:

<table>
<thead>
<tr>
<th>Unit/area</th>
<th>Total shifts</th>
<th>Number filled by bank or agency staff</th>
<th>Proportion filled by bank or agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate 18</td>
<td>4438</td>
<td>399</td>
<td>9.0%</td>
</tr>
<tr>
<td>Gate 18a, Labour ward</td>
<td>11011</td>
<td>712</td>
<td>6.5%</td>
</tr>
<tr>
<td>Pinderfields Birth Centre</td>
<td>2705</td>
<td>92</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18154</strong></td>
<td><strong>1203</strong></td>
<td><strong>6.6%</strong></td>
</tr>
</tbody>
</table>

The table below shows the total number and proportion of qualified nursing and midwife shifts left unfilled from April 2017 to March 2018 in maternity services at the location:

<table>
<thead>
<tr>
<th>Unit/area</th>
<th>Total shifts</th>
<th>Number unfilled by bank or agency staff</th>
<th>Proportion of shifts not filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate 18</td>
<td>4438</td>
<td>373</td>
<td>8.4%</td>
</tr>
<tr>
<td>Gate 18a, Labour ward</td>
<td>11011</td>
<td>800</td>
<td>7.3%</td>
</tr>
<tr>
<td>Pinderfields Birth Centre</td>
<td>2705</td>
<td>69</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18154</strong></td>
<td><strong>1242</strong></td>
<td><strong>6.8%</strong></td>
</tr>
</tbody>
</table>

The service used NHS professionals (NHSP) to fill gaps in the planned number of staff. A number of substantive staff were signed up to NHSP, and the agency also provided a number of familiar staff to the maternity unit, this provided continuity.

Senior management had implemented changes in the provision of absence staffing cover since our last inspection. They had encouraged more substantive staff to join NHSP, increasing bank
staff availability. They also offered unfilled shifts as overtime to contracted staff, if not filled by NHSP staff, two weeks before shifts commencing. Agency staff were now used as a last resort. We compared spending on bank and agency staff in November 2017 to spending in March 2018. We saw that agency staff spend had fallen by 92%, and bank staff spend had increased by 77%. Figures were not inclusive of overtime spend.

**Midwife to birth ratio**

The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance; Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007).

From January 2017 to December 2017, the trust had a ratio of one midwife to every 26.88 births. This was similar to the England average of one midwife to every 25.46 births, and met the recommended minimum ratio of one midwife to every 28 births. The service did not include maternity support workers within the establishment.

*(Source: Electronic Staff Records – EST Data Warehouse: 04 June 2018)*

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the midwife to birth ratio as 1:28 at the trust. This met the recommended minimum ratio.

Women told us they had received continuity of care and one-to-one support from a midwife during labour (1:1 care). Senior staff we spoke with during the inspection reported the percentage of women given one-to-one support from a midwife was very good. Data provided by the trust showed between July 2017 and June 2018, 98% of women experienced 1:1 care in labour at the location.

There were two band seven community midwifery team leaders at the service. One responsible for the Pontefract community team and Wakefield community team, and one responsible for the Dewsbury community team. The Wakefield community team covered the Pinderfields Hospital locality, and the team office was based off-site.

There were 17.2 WTE midwives in the Wakefield community midwifery team. The average community caseload within the Wakefield community team was 166 women per WTE midwife (based on number of bookings), this was not in line with national recommendations. The current recommended Birthrate plus ratio, allowing for some changes in allowances and the NICE Guidance since 2009, is 96 cases per WTE midwife.

The service had recently begun reporting midwifery caseloads against the number of live pregnancies, as using the number of bookings would include a proportion of women who experience an early miscarriage and therefore do not require ongoing community care beyond the booking appointment. Following this methodology, the community caseload within the Wakefield community team was 72 women per WTE midwife (based on number of live births). Using the live birth denominator is a useful additional measure of community midwifery activity. However, current guidance is calculated using cases (number of bookings). In the guidance, the term ‘cases’ is used rather than ‘births’ as not all women will have delivered in the local maternity unit, so will not be included in the total births for the obstetric unit. The total number of cases will reflect the local population of women having delivered along with those that may not complete their pregnancy.
Medical staffing

The trust could not provide staffing data specific to medical staff within maternity services; as some medical staff worked across obstetrics and gynaecology services.

Planned vs actual

The trust reported planned versus actual medical (obstetrics and gynaecology) staffing for the period April 2017 to March 2018. Data showed 51.62 whole time equivalent (WTE) planned staff against 46.09 whole time equivalent (WTE) actual staff. This equated to a permanent medical staffing fill rate of 89.3% within obstetrics and gynaecology services at the trust. Across obstetrics and gynaecology services at the trust, 10.7% of medical shifts were filled by bank and locum staff.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 7% among medical (obstetrics and gynaecology) staff, meeting the trust’s 9% target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 0% among medical (obstetrics and gynaecology) staff.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 2% among medical (obstetrics and gynaecology) staff, meeting the trust’s 4.8% target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018, the trust reported 818 medical (obstetrics and gynaecology) shifts were filled by bank staff, and 881 medical (obstetrics and gynaecology) shifts were filled by locum staff. Across obstetrics and gynaecology services at the trust, 10.7% of medical shifts were filled by bank and locum staff. The trust attributed medical and bank agency use to vacancies.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was about the same.
Staffing skill mix for the 46.3 whole time equivalent staff working in maternity at The Mid Yorkshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>47%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The Royal College of Gynaecologists (RCOG) Safer Childbirth (2007) report included recommendations regarding staffing levels on the labour ward based on the number of deliveries within a unit, with emphasis on delivering a consultant-based service. In England, these recommendations were incorporated into Clinical Negligence Scheme for Trusts (CNST) standards and thus there was the financial impetus to effect change.

In 2016, the RCOG published ‘Providing quality care for women: obstetrics and gynaecology workforce’. This report updated previous guidance within the Safer Childbirth (2007) report in light of subsequently published evidence. The 2016 report recommended that all consultant-led maternity units should have a minimum labour ward consultant presence during working hours Monday to Friday (8:30 – 17:00). They recommended aiming to extend this to every day of the week to provide the same quality of service over seven days, in line with the aims of NHS England’s seven-day service standards.

The delivery suite had 98 hours per week consultant presence. This was based on an onsite consultant presence for 15 hours per day Monday to Friday (08:00 to 23:00) and 11.5 hours per day Saturday and Sunday (08:00 to 19:30). This met minimum labour ward consultant presence of 60 hours during working hours Monday to Friday (8:30 – 17:00) (RCOG 2007, 2016), with similar provision provided at weekends (and demonstrated working towards NHS England’s seven-day service standards).

Establishment included an obstetric specialist trainee (grade 3 to 7) or staff grade doctor (registrar) and a specialist trainee or GP trainee (grade 1 to 2, senior house office) present on site at all times.

The Trust has implemented several actions to proactively manage medical staffing within the service, and extend and diversify the medical workforce.

Since our last inspection (May 2018), actions had included reviewing and revising recruitment materials, working with specialist recruitment agencies supporting international and permanent recruitment, and reviewing and revising job descriptions.
The service had also held a rota redesign project looking at all junior doctor rotas earlier in the year, and allocated dedicated junior doctors to cover the labour ward, antenatal/postnatal wards and triage following feedback from teams.

The service had gained permission to implement over-recruit medical staff for the service. They had recently secured permission to recruit two additional speciality doctors; to reduce reliance on junior doctors and trainees. In addition, they had recruited a consultant obstetrician (June 2018) and were in the process of interviewing for another.

The service recognised a shortfall of middle grade obstetricians in the service. This is a national problem, as highlighted in RCOG, Providing quality care for women: obstetrics and gynaecology workforce, 2016. To help address this, the management team told us that the service made use of two long-serving middle-grade locums.

The service had a dedicated elective (planned) caesarean section team, and had added a third consultant. This had helped reduce medical staffing burden on the labour ward.

There was a dedicated anaesthetic team for elective caesarean sections. There was a separate team for emergency caesarean sections and epidurals as required.

Records

We saw secure storage facilities for records at the service. Electronic records were also kept, and procedures for safe storage were in line with data protection requirements.

Handheld notes were carried by women throughout pregnancy, in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3.

The service completed bi-annual record keeping audits. We reviewed the audit completed in December 2017, which was submitted to the Maternity Clinical Governance Group. Across maternity services at the trust, a total of 167 sets of maternity case notes and/or hand held notes were audited. These included 57 antenatal records, 71 intrapartum records, and 39 postnatal records.

The results showed improved compliance with antenatal record keeping, particularly around documentation of CTG monitoring when compared to the previous audit. There was also a significant compliance increase in full recording of mental health risk assessments, and birth plans. Recording compliance for intrapartum drug sensitivity/allergy and verbal consent for all intrapartum procedures had increased since the last audit was undertaken. Postnatal documentation of perineal trauma (if appropriate) was also improved.

Areas of concern included a fall (from the previous audit) from 97% to 89% in recording maternal pulse on the first auscultation of the fetal heart, and also a reduction from 98% to 75% in recording the fetal heart every 5 minutes for over a minute within the second stage of labour. Similarly, a reduction from 78% down to 58% was seen in palpating and documenting maternal pulse every 15 minutes in the second stage of labour. There was also a reduction from 98% to 54% in documenting that consent had been obtained for all postnatal procedures, interventions and examinations.

Following the audit, an action plan was put in place. Ongoing activity to monitor changes in compliance included a random sample of eight maternity records per month at each location from January 2018, to be collated for the next record audit report.

At our inspection, we reviewed 12 sets of patient records and found that a risk assessment for obstetric / medical history and social history was carried out in all cases. A risk assessment for mental health history had been documented in 11 out of 12 cases. Care pathways (including changes to care pathways) were clearly documented in all 12 records reviewed.
There were good standards of intrapartum documentation for the five relevant care records reviewed. This included documentation of risk assessments (using SBAR forms), modified early warning scores (MEWS), and appropriate labelling and storage of CTGs.

In the four postnatal care records reviewed, handover (using SBAR), risk assessments, and plotting of MEWS (and escalation where appropriate) were all appropriately recorded. All notes were dated and signed with NMC/GMC numbers. We observed that ‘fresh eyes’ had been documented in two of the three applicable records reviewed.

During the inspection, we saw three separate entries on the maternity risk register relating to maternity service records; these were rated as presenting a moderate to high risk. All three entries centred around issues with the main maternity record software system. Staff we spoke with during our inspection reported the system was sometimes cumbersome to navigate, but overall, they found the system adequate. The senior management team were acutely aware of the risks involved, and were currently reviewing options to implement a new paperless system when the current software license expired (2019). The service had also developed a task and finish group to plan, evaluate and adopt a paperless postnatal record. We reviewed relevant risk register entries and saw that risks had been appropriately monitored and mitigated. We also saw there was an electronic maternity system action plan 2018 in place, which showed progress towards against a new digital maternity plan for the service.

**Medicines**

We reviewed seven prescription charts and found them completed in line with trust policies.

Medicines that required storage at a low temperature were stored in specific locked fridges. Medicines that did not require refrigeration were stored in locked cupboards and trolleys in all clinical areas. Fridge and cupboard temperatures were monitored remotely.

Medicines and equipment required in emergencies were appropriately stored and checked daily to ensure they were fit for use.

Records showed the administration of controlled drugs were subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded. Records showed controlled drugs were checked in line with trust policy.

The trust audited the safe storage of medication on maternity wards and clinics twice a year, and report results to the Medicines Optimisation Group and at a divisional level.

The April 2018 medicines audit showed that Pinderfields maternity services (including theatres and EPAU) were compliant with the safe and secure storage of medicines, and no expired medicines were identified. However, the audit did find that oral/enteral syringes were not present in the treatment rooms where oral medicines were kept; this was identified as an area for improvement and follow up.

However, during our inspection we identified some printed copies of patient group directions (PGDs) that allowed midwives to administer certain medicines without a prescription, were out of date. Individual nurses who could administer the medicine under the PGD were not listed and had not signed the individual authorisation form attached to the end of each PGD, as required by trust policy.

Staff had access to up to date electronic medicine policy guidelines via the trust intranet and the trust pharmacist visited the wards and departments four times per week.

The service had recently introduced a self-medication service; and provided self-medication lockers so women could self-medicate. The patient-led self-medication service was implemented...
in November 2017 on Gate 18, the antenatal and postnatal ward, and on the elective caesarean section recovery ward at Pinderfields Hospital; using the trust approved standard operating procedure for consent and risk assessment. We saw evidence that women who had utilised the service provided positive feedback. Senior staff also informed us that the project had improved appropriate and timely administration of medication. In addition, it had also reduced discharge waiting times for take home medications, as these were dispensed as in-patient medication for continued use at home.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents which were classified as never events for maternity.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant), with 2 incidents (40% of total incidents).

- VTE meeting SI criteria, with 1 incident (20% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant), with 1 incident (20% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only, with 1 incident (20% of total incidents).

*(Source: Strategic Executive Information System (STEIS))*
In addition to those described above, a serious incident had occurred in maternity services in May 2018. This was classified as Maternity/Obstetric incident meeting SI criteria: baby only.

All six serious incidents reported within maternity services during the period May 2017 to May 2018 had occurred or originated at Pinderfields Hospital.

The trust had a policy for reporting incidents, near misses and adverse events in maternity services. Staff we spoke with said they were encouraged to report incidents and were aware of the process to do so.

Staff reported incidents on the trust's electronic incident-reporting system. The governance midwife and consultant obstetrician (both RCA trained) lead on serious incident investigations, supported by multidisciplinary colleagues as necessary.

We reviewed three completed serious incident root cause analysis (RCA) reports and associated actions plans, which identified areas of good practice and areas of concern, contributory factors and recommendations. We observed appropriate referral to external agencies, and inter-agency working, where appropriate.

We reviewed minutes of Maternity Clinical Governance Group meeting minutes (December 2017 to June 2018) and found discussion of serious incidents, RCA reports, clinical incidents and the RCA action log were standing agenda items.

During our inspection, we reviewed the maternity service RCA action log and found three outstanding actions; these had been granted an extension and appropriately monitored. We saw actions from one serious incident placed on hold due to external agency involvement. An additional 11 actions from a recent serious incident were due to be added to the log, pending commissioner approval.

Between July 2017 and June 2018, there were 1791 incidents reported by maternity services at the location. The trust provided summary information data, which thematically categorised incidents. However, we were not able to ascertain levels of harm (for example, no harm, moderate harm, or severe harm) from the data. Nor were we able to identify specific areas of the maternity services to which incidents related.

As shown in the table below, of the 1791 incidents, most related to ‘adverse events that affect staffing levels’ (n445, 24.8%), ‘labour or delivery – other’ (n230, 12.8%), ‘post-partum haemorrhage over 1,000ml’ (n98, 4.5%), and ‘Injury or poor outcome for the mother’ (n86, 4.8%). We amalgamated 43 categories where less than 10 incidents per category were reported over the 12-month period.

<table>
<thead>
<tr>
<th>Incident category</th>
<th>Total incidents reported at location</th>
<th>Proportion of incidents reported at location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse events that affect staffing levels</td>
<td>445</td>
<td>24.8%</td>
</tr>
<tr>
<td>Labour or delivery - other</td>
<td>230</td>
<td>12.8%</td>
</tr>
<tr>
<td>Post-partum haemorrhage &gt; 1,000ml</td>
<td>98</td>
<td>5.5%</td>
</tr>
<tr>
<td>Injury or poor outcome for the mother</td>
<td>86</td>
<td>4.8%</td>
</tr>
<tr>
<td>Transfer</td>
<td>81</td>
<td>4.5%</td>
</tr>
<tr>
<td>Transfusion of Blood related problem</td>
<td>81</td>
<td>4.5%</td>
</tr>
<tr>
<td>Admission</td>
<td>63</td>
<td>3.5%</td>
</tr>
<tr>
<td>Category</td>
<td>Incidents</td>
<td>Percentage</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Administration/supply of a medicine from a clinical area</td>
<td>41</td>
<td>2.3%</td>
</tr>
<tr>
<td>Laboratory investigations</td>
<td>36</td>
<td>2.0%</td>
</tr>
<tr>
<td>Medical device/equipment</td>
<td>33</td>
<td>1.8%</td>
</tr>
<tr>
<td>Test results / reports</td>
<td>33</td>
<td>1.8%</td>
</tr>
<tr>
<td>Communication between staff, teams or departments</td>
<td>33</td>
<td>1.8%</td>
</tr>
<tr>
<td>Patient's case notes or records</td>
<td>30</td>
<td>1.7%</td>
</tr>
<tr>
<td>Problem with the referral from primary to secondary care</td>
<td>29</td>
<td>1.6%</td>
</tr>
<tr>
<td>Possible delay or failure to Monitor</td>
<td>27</td>
<td>1.5%</td>
</tr>
<tr>
<td>Appointment</td>
<td>27</td>
<td>1.5%</td>
</tr>
<tr>
<td>Emergency Caesarean Section</td>
<td>25</td>
<td>1.4%</td>
</tr>
<tr>
<td>Diagnosis - other</td>
<td>22</td>
<td>1.2%</td>
</tr>
<tr>
<td>Electronic Patient Record</td>
<td>20</td>
<td>1.1%</td>
</tr>
<tr>
<td>Implementation of care or ongoing monitoring - other</td>
<td>19</td>
<td>1.1%</td>
</tr>
<tr>
<td>Needlestick injury or other incident connected with sharps</td>
<td>18</td>
<td>1.0%</td>
</tr>
<tr>
<td>Slips, trips, falls and collisions</td>
<td>17</td>
<td>0.9%</td>
</tr>
<tr>
<td>Treatment, procedure - other</td>
<td>16</td>
<td>0.9%</td>
</tr>
<tr>
<td>Assessment - other</td>
<td>16</td>
<td>0.9%</td>
</tr>
<tr>
<td>Pressure sore / decubitus ulcer</td>
<td>15</td>
<td>0.8%</td>
</tr>
<tr>
<td>Elective Caesarean Section</td>
<td>15</td>
<td>0.8%</td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>14</td>
<td>0.8%</td>
</tr>
<tr>
<td>Administration of assessment</td>
<td>14</td>
<td>0.8%</td>
</tr>
<tr>
<td>Discharge</td>
<td>13</td>
<td>0.7%</td>
</tr>
<tr>
<td>Infrastructure or resources - other</td>
<td>13</td>
<td>0.7%</td>
</tr>
<tr>
<td>Lack of/delayed availability of facilities/equipment/supplies</td>
<td>13</td>
<td>0.7%</td>
</tr>
<tr>
<td>Environmental matters</td>
<td>12</td>
<td>0.7%</td>
</tr>
<tr>
<td>Appointment, Admission, Transfer, Discharge - other</td>
<td>11</td>
<td>0.6%</td>
</tr>
<tr>
<td>Information - other</td>
<td>11</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other categories (n43) (with less than 10 incidents reported per category over the 12-month period)</td>
<td>134</td>
<td>7.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1791</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
In January 2018, an entry had been added to the maternity risk register regarding five incidents in which the tip of the uterine suture (Ethicon vicryl w9231) has been found to be missing on completion of surgery. The women were x-rayed and the environment searched but the tips could not be located. There was an investigation which found all the uterine sutures had different batch numbers (batches were removed from use), and incidents were not specific to a clinician. The service reported the incidents to the Medicines and Healthcare Products Regulatory Agency (MRHA). The obstetric team had also made changes to practice. The entry was subsequently removed from the risk register. During our inspection, we observed a surgery in which the incident reoccurred; however, the broken tip of the uterine suture was located. We saw this was appropriately recorded as an incident, and escalated for immediate action. The batch of sutures was removed from use. An investigation was ongoing to review clinicians’ techniques, and the risk had been reopened on the register.

At our previous inspection in May 2017, we identified that the service was learning from incidents, but were not informing staff why practice had changed. During our recent inspection, we found staff were able to tell us about incidents that had occurred and learning from these.

The service used internal communication methods to inform staff of learning and changes to practice. Monthly maternity clinical governance reports were distributed (emailed directly) to staff and showed the number, location, severity of incidents, and incident themes. Comparative data was presented from previous months to map incident numbers, locations and themes over time.

Where relevant, the governance report highlighted discrepancies between incident reports and maternity dashboard figures, and noted these as missed opportunities for learning and good practice to be shared. It was conceded in the report that some incidents may have been reported under other categories.

We saw evidence of specific learning events and investigations posted in clinical areas for staff to review. The service used a trust-wide monthly newsletter and weekly safety brief to inform staff of learning and changes to practice, and to keep staff informed of risks which faced the directorate. We observed the safety brief displayed in clinical areas. We also saw some clinical areas had their own ‘local’ newsletters displayed that detailed the top reported Datix incidents in those particular areas. For example, the ‘My Birth Centre and Triage’ newsletter (May 2018) showed the top two reported incidents related to adverse events that affect staffing levels, and patient case notes or records. Staff we spoke with across the service told us that incidents and learning were also discussed at the labour ward forum, team meetings, and handovers.

Obstetric and neonatal staff attended perinatal mortality and morbidity meetings; these took place quarterly. At our last inspection of the service in May 2017, we found no recommendation of changes to practice in the meeting minutes and actions plans were not completed.

Following our recent inspection, we requested perinatal mortality and morbidity meeting minutes for the previous six months and evidence action plan completion. The trust provided the Perinatal Clinical Governance Meeting minutes for May 2018. We saw that four cases were on the agenda for the May 2018 meeting. However, the chair had decided to allocate the whole session to a (serious incident) case that had an unexpected poor outcome. A neonatal pathologist from another trust attended via video link to discuss the case. We saw evidence of constructive discussion around relevant aspects of practice with a view of learning from MDT members how to prevent similar future poor neonatal outcomes. Discussion was based on the serious incident report, case note review and the CCG review panel’s report; and the consultant body present in the perinatal meeting suggested changes to clinical and teaching practice as a result of lessons learned.

As described above, we found examples of case reviews and discussion highlighting notable practice and areas of improvement; however, we saw no evidence of associated action plan completion. The May 2018 minutes detailed that minutes of previous meetings were not discussed, as they were routinely circulated to the whole consult body to verify the true reflection of the meeting. In addition, that matters arising from the minutes were discussed via email. The
minutes did not specify who was present at the meeting. We could not be assured that changes to practice in meeting minutes were implemented, monitored, and actions completed.

The Duty of Candour (DoC) is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm. Duty of candour was evidenced in the completed serious incident investigation and meeting minutes we reviewed. The staff we spoke with at the midwifery-led unit said they were open and honest with women if things went wrong.

**Safety thermometer**

The service submitted data to the national maternity safety thermometer. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced ‘harm free’ care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This is a point of care survey that is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women’s homes and community postnatal clinics.

Maternity safety thermometer data was presented for all maternity settings at the trust, hospital care, midwifery-led unit care, and community care.

When we reviewed the data, we found significant gaps in reporting for midwifery-led care and community care. We therefore report data at trust-wide level.

Selected trust-wide maternity safety thermometer showed that from May 2017 to May 2018:

- The proportion of women that had a maternal infection was 2.65%.
- The proportion of women who were left alone at a time that worried them was 0.89%.
- The proportion of women with concerns about safety during labour and birth not taken seriously was 28.14%.
- The proportion of women and babies that received physical harm free care was 88.53%.
- The women’s perception of safety composite measure was 71.08%.

The service also submitted harm free care data to the national classic safety thermometer. From May 2017 to May 2018 data showed 100% of women within obstetric services received harm free care.

The maternity service submitted data to the maternity safety thermometer, but did not routinely use the tool to support safety and improvement; as they considered more accurate and informed tools existed which better supported this. The service considered the tool unrepresentative of actual performance. This, they said, was due to significant restrictions on the data, including snapshot data and low numbers which are not representative of all service users, and inconsistency in data collection methodologies across organisations. The service instead said they valued maternity dashboard, FFT and patient surveys (which they considered provided richer and more representative data), alongside themes from complaints, incidents, and serious incidents to inform an accurate picture of the quality of the service. We saw evidence that this evidence drove improvements. The service noted there is currently a national review of the safety thermometer as to its value as an improvement tool.
Is the service effective?

Evidence-based care and treatment

The delivery of care and treatment provided to women was based on guidance issued by professional and expert bodies. This included the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence based practice.

There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU) and a transitional care ward, which was staffed jointly by neonates and maternity.

Policies and procedures were available on the trust's intranet and were approved by the clinical governance group. Staff told us that policies and guidance could be accessed on the trust intranet, which they found easy to navigate. All the electronic policies and guidance we reviewed across the service were found to be current and reflected quality standards and national guidance.

The minutes of Maternity Governance Meeting minutes (December 2017 to June 2018) showed monitoring and review of controlled documents within the service.

The manually held policies and clinical guidelines we saw on site were seen to be within date with version control.

At our previous inspection in May 2017, we found a lack of additional audit activity following the amalgamation of services on the Pinderfields site.

At our recent inspection, we saw that a quality data and audit midwife had been recruited in April 2018. Prior to this, the post had been vacant for more than 12 months. The quality data and audit midwife was responsible for producing the annual maternity audit programme, in conjunction with the governance midwife. In addition, for allocating and supporting staff with clinical audit, to ensure the plan was delivered within timescale.

We reviewed an update to the clinical audit programme and action plan for obstetric and maternity services (dated to July 2018). We saw several local audits marked as ongoing that had surpassed dates of estimated completion. In some cases, audits had been significantly delayed; for example, the Antenatal Risk Assessment (level 1) audit was due to be completed by March 2017. The governance midwife and IHoM informed us that the quality data and audit midwife had made good progress with backlogs since their appointment, and had prioritised activities for completion. We saw evidence of this, and noted that national audit programmes were on-track overall. However, we saw several local audits marked as ongoing that had surpassed dates of estimated completion. For example, the antenatal risk assessment (level 1) audit was due to be completed by March 2017. We also learned that the service had not conducted a MEWS audit in the 12 months prior to our inspection. The service told us this was ongoing and later provided evidence of completion in the form of preliminary data (August 2018); although this had not been quality assured. We could not find evidence in the audit programme that a ‘fresh eyes’ audit had been conducted in 2017 to 2018. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). We saw a WHO Safe Surgery audit was due to commence March 2017, with an estimated finish date of December 2017. However, the July 2018 update detailed that this was still ongoing. Following our inspection, the trust informed us that the WHO checklist audit was due to be completed December 2018. We could not see that a ‘swab count’ audit had been conducted in 2017 to 2018; but did see that a ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. The service reported that it did not undertake pain audits.

The service reported that audit activities were on-track to be completed within adjusted timescales. We saw audit activity was entered on the maternity risk register and this was appropriately
monitored and reviewed. However, we noted significant delays with the local maternity audit programme overall.

**Nutrition and hydration**

The service had a current infant feeding policy, based on UNICEF UK Baby Friendly Initiative standards for maternity and neonatal (UNICEF, 2014), relevant NICE guidelines (NICE, 2008; NICE, 2017), and the Healthy Child Programme (DOH, 2009).

The trust had implemented United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards, and had achieved full accreditation.

Midwives were required to attend a one-day UNICEF Breastfeeding and Relationship building course within six months of their start date.

There was an infant feeding coordinator. Their role included training staff, provision of frenulotomy (tongue-tie) clinics, and supporting breastfeeding mothers on the postnatal ward and in the community.

Since our last inspection in May 2017, the service had increased their breastfeeding initiation target from 60% to 70%. Trust-wide maternity dashboard data showed that from July 2017 to June 2018, the proportion of women who had commenced breast feeding within 48 hours of delivery was 69.6%. This was similar to the trust's target.

Yorkshire and Humber maternity dashboard data showed from April 2017 to December 2017, the proportion of women who had commenced breast feeding within 48 hours of delivery ranged between 62.5% to 69.6% per quarter at the trust (mean 67.2%). This was about the same as Yorkshire and Humber averages for the period, which ranged from 64.4% to 73.3% per quarter (mean 68.6%).

Women who chose to formula feed their baby were asked to bring their own powdered formula and bottles into the unit. Women were supported to make their formula correctly throughout their stay on the ward.

There was a milk kitchen on the postnatal ward. This provided a dedicated space for families to prepare formula milk for their babies away from the traditional pantry. The milk kitchen was used to give families privacy, one-to-one demonstrations, and opportunities to ask questions, in order to support good infant-feeding practice.

The service worked with community services and public health to provide continuity of support for breastfeeding once women had left the hospital. The trust supported local, volunteer-run, weekly, breastfeeding cafes, which women could attend for support and advice.

The choice of inpatient meals took account of individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good. The service had introduced a token system to identify which women were able to have a hot meal whilst on the labour suite.

Refreshment facilities were available in antenatal clinic waiting areas.
Pain relief

Women received detailed information of the pain relief options available to them, this included Entonox piped directly into the delivery rooms.

The obstetric led unit had a birthing pool, with a ceiling hoist in case of emergency. Women who required additional monitoring during labour were also able to use this pool.

NICE NG4, Safe Maternity Staffing guidance recommends that services capture delays of more than 30 minutes in providing pain relief. The trust told us that the maternity service did not undertake pain audits. They reported that women in the care of the service were managed on an individual basis, as labour and postnatal care is a unique experience.

This service did not record mean/median time data from women requesting an epidural to them receiving it. However, we saw a 24-hour anaesthetic and epidural service was provided. The anaesthetic cover available to the maternity service included a resident team and a backup rota. Senior staff told us that this ensured timely access to women requesting epidural.

The birthing centre had two birthing pools and equipment to support active labour; such as active birthing couches, birthing balls, and TENS machines.

Pharmacological pain relief options included diamorphine, meptazinol (meptid), and pethidine. Women attending the birthing centre who requested epidural analgesia were transferred to the labour ward.

The service did not actively promote alternative therapies, for example, hypnobirthing. However, we were told they supported women who chose this method of pain relief; and we saw patient information leaflets on display that described the potential benefits of different holistic pain relief methods.

Patient outcomes

National Neonatal Audit Programme

The National Neonatal Audit programme (NNAP) was established in 2006 to support professionals, families and commissioners in improving the provision of care provided by neonatal services which specialise in looking after babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment.

The NNAP produces yearly national reports, the latest of which is the NNAP 2017 Annual Report on 01 January 2016 to 31 December 2016 data, which was published September 2017.

In the 2017 NNAP report, Pinderfields Hospital performance in the two measures relevant to maternity services was as follows:

- Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 125 eligible cases identified for inclusion, 84.3% of mothers were given a complete or incomplete course of antenatal steroids.

The hospital did not meet the audit’s recommended standard of 85% for this measure.

However, the result was within expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.
• Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

2017 report data showed 23 eligible cases were identified for inclusion, and of these, 4.4% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was lower than the national aggregate of 43.5%, and put the hospital in the bottom 25% of all units.

The average proportion of women in the Yorkshire & Humber region who were given magnesium sulphate in the 24 hours prior to delivery was 37% during this period.

However, following our inspection, the trust provided us with more up to date information which showed the service had improved their performance. Data showed that from July 2017 to July 2018, 62% of eligible women were administered magnesium sulphate in the 24 hours prior to delivery; this was in line with national and regional averages.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

From January to December 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections was as expected and rates for emergency was as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>MID YORKSHIRE HOSPITALS NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>607</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.6%</td>
<td>946</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.0%</td>
<td>1,553</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of:

Source: Hospital Episode Statistics January 2017 to December 2017
Note: Delivery methods are derived from the primary procedure code within a delivery episode.

At our previous inspection in May 2017 we found that between April 2016 and March 2017, the service reported a trust wide caesarean section rate of 30%, which exceeded the target set by the service.

At our most recent inspection, we found the trust wide caesarean section rate had been reduced. From July 2017 to June 2018, trust-wide maternity dashboard data showed the proportion of elective (planned) caesarean sections was 11%; within the trust's target threshold of 11%. Over the same period, the proportion of emergency caesarean sections was 16.5%; slightly above the trust’s threshold target of 15.2%. The total proportion of caesarean sections was 27.5%; slightly above the trust’s target threshold of 26.2%.

In relation to other modes of delivery from January to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:
Delivery method rates were similar to England averages.

From July 2017 to June 2018, trust-wide maternity dashboard data showed the proportion of instrumental deliveries was 10.5%; better than the trust's target threshold of 12.9%.

Over the same period, the proportion of non-interventional (normal) deliveries was 62.1%; and better than trust target of 60.9%.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

At our previous inspection of the service in May 2017, we found that between April 2016 and March 2017 the trust wide induction of labour rate was 37%, and above the trust target threshold of 30%.

We saw a reduction in the trust-wide induction of labour rate at our recent inspection of the service. Maternity dashboard data showed that from July 2017 to June 2018, the induction of labour rate was 34.3% at trust level.

However, the rate was still above the trust target threshold of 30%, and higher than the England average (29.4%) (NHS Digital, NHS Maternity Statistics, England 2016-17. Published November 2017).

From July 2017 to June 2018, trust-wide maternity dashboard data showed the proportion of pre-term babies delivered before 37 weeks gestation was 8.1%. This was the same as the regional average. We reviewed Yorkshire and Humber maternity dashboard data for quarter 3 of 2017-2018 (October to December 2017, the most recent available at the time of inspection) and saw the Yorkshire and Humber average for the period was 8.1%.

From July 2017 to June 2018, trust-wide maternity dashboard data showed the proportion of babies with low birth weight (under 2200g) born at term was 0.4%. This was better than the regional average. We reviewed the Yorkshire and Humber maternity Dashboard for quarter 3 of 2017-2018 (October to December 2017) and saw the average proportion of babies with low birth weight (under 2200g) born at term was 0.9%.

**Maternity active outlier alerts**

As of May 2018, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)**

The trust took part in the MBRRACE audit. The latest MBRRACE report (June 2018) showed their stabilised and risk-adjusted extended stillbirth rate (per 1,000 births) was 3.78. This was similar to the average for the comparator group rate of 3.74.
Their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.08. This was slightly higher than the average for the comparator group rate of 4.95.

MBRRACE data was based on information collected from January 2016 to December 2016 (and published in the most recent MBRRACE report available at the time of inspection).

(Source: MBRRACE UK)

From July 2017 to June 2018, maternity dashboard data showed the total proportion of stillbirths was 0.62% (n38). Of these, data showed that 36 stillbirths had occurred in the antenatal period, 14 of which had occurred at term (after 37 weeks gestation). Two stillbirths had occurred in the intrapartum period. The maternity dashboard did not display trust target thresholds for stillbirths.

We reviewed the Yorkshire and Humber maternity dashboard. Data from April 2017 to December 2017 showed the quarterly total stillbirth rate (per 1000 births) for the trust ranged from 3.8 to 4.0. This was similar to or better than Yorkshire and Humber averages for the period, which ranged from 3.8 to 4.3 per quarter.

The service had a MBRRACE Perinatal Confidential Enquiry action plan (2017). The action plan showed the service was compliant against all applicable recommendations, with the exception of one. The action plan detailed that the home birth guideline was currently being updated to include practical guidance around resuscitation of a baby born in extremis and out of hours in their service; with deadline set for August 2018.

The service completed a gap analysis against the MBRRACE Saving Lives, Improving Mothers’ Care UK report in December 2017. The associated action plan listed 28 actions required to achieve compliance. The service was partially or non-compliant with respect to approximately half of the recommendations listed. Actions to achieve compliance were assigned a lead, and completion date. Outstanding actions were due to be completed between September 2018 and December 2018.

The service had completed an Each Baby Counts Recommendations gap analysis, and had produced an associated action plan (October 2017). The action plan detailed 18 recommendations, of which 17 were completed. An outstanding recommendation, to employ a ‘fresh ears’ approach to intermittent auscultation, was under consideration and the service was in discussion with other trusts as to the approach to take. A completion date of October 2018 had been set for the outstanding item.

There was a standard operating procedure for maternity services stillbirth reviews. The SOP set out the systems for reporting antenatal and in-uterine stillbirths, and the process for the review of antenatal in-uterine deaths (IUD) following the introduction of the Perinatal Mortality Review Tool (PMRT). The PMRT sets out recommendations and guidance for conducting perinatal mortality reviews.

There was a public health lead midwife in post. They met fortnightly with the consultant lead for stillbirths and the bereavement midwife to undertake reviews of reported stillbirth incidents. Cases requiring further investigation were escalated to the governance midwife and consultant clinical lead for governance for further discussion.

We reviewed 13 completed still birth review reports, which identified areas of good practice and areas of concern, contributory factors and recommendations.

There was a Maternity Services Still Birth Group in place at the service. The group was chaired by the Maternity Public Health Matron, and included consultant obstetric, governance, screening and bereavement leads. Standing agenda items included stillbirth rates and associated audits and reports, bereavement services, and guidelines. The group were responsible for developing, implementing and monitoring a still birth action log. We saw a version dated to July 2018, which showed extensive evidence of work undertaken to reduce the stillbirth rate. Actions were
organized by theme and area of learning, were dated, with a named lead, and cited evidence of completed actions.

The Maternity Services Still Birth Group Meeting minutes for July 2018 reported that the trust were fully compliant with the Saving Babies Lives Stillbirth Bundle; a care bundle for stillbirth prevention, through improved antenatal recognition of foetal growth restriction.

Trust-wide maternity dashboard data showed that from July 2017 to June 2018, the proportion of normal deliveries resulting in a 3rd or 4th degree tear was 2.3%. The maternity dashboard did not display a trust target for 3rd or 4th degree tears.

We reviewed the Yorkshire and Humber maternity dashboard. Data from April 2017 to December 2017 showed quarterly 3rd or 4th degree tear rates for normal deliveries ranged between 1.6% to 2.5% at the trust. This was similar to or below Yorkshire and Humber averages for the period, which ranged from 2.1% to 2.4% per quarter.

Trust-wide maternity dashboard data showed that from July 2017 to June 2018, the proportion of instrumental deliveries resulting in a 3rd or 4th degree tear was 7.1%. The maternity dashboard did not display a trust target for 3rd or 4th degree tears.

Yorkshire and Humber maternity dashboard data from April 2017 to December 2017 showed quarterly 3rd or 4th degree tear rates for normal deliveries ranged between 3.3% to 6.0% at the trust. This was better than or similar to Yorkshire and Humber averages for the period, which ranged from 5.7% to 6.6% per quarter. Comparatively, we note the average rate at the trust from July 2017 to June 2018 (7.1%) was marginally higher than previous trust and Yorkshire and Humber averages.

Trust-wide maternity dashboard data showed that from July 2017 to June 2018, the proportion of women who experienced a postpartum haemorrhage (PPH) of more than 1500mls was 4.1%. Over the same period, the proportion of women who experienced a PPH of more than 2500mls was 0.8%. The maternity dashboard did not display a trust target for PPHs.

Yorkshire and Humber maternity dashboard data from April 2017 to December 2017 showed the proportion of women who experienced PPH of more than 1500mls ranged between 2.4% to 4.6% per quarter. This was sometimes slightly worse than Yorkshire and Humber averages for the period, which ranged from 2.7% to 2.8% per quarter.

From October 2017 to June 2018, there were 462 transfers from the birthing centre to the labour ward. The service had changed their data collection and recording methods in October 2017, to monitor transfers by site. The service provided the raw number of women transferred over this timeframe, and did not provide proportions.

Data provided by the trust showed the stage of pregnancy (antenatal, intrapartum, postnatal) at which the transfer took place, and reasons for transfer.

Data showed that of the 462 transfers, 35% (n163) were antenatal transfers, 45% (n210) were intrapartum transfers, and 19% (n89) were postnatal transfers.

Using the number of babies delivered at the birth centre from October 2017 to June 2018 (n663) to calculate a proxy denominator (n873) suggests an intrapartum transfer rate of 24%. This appeared in line with a national study of transfers from alongside midwifery led units (21.2%) (Birthplace in England national prospective cohort study, 2011).

Of the 210 intrapartum transfers, most were recorded against failure to progress in the first stage of labour (n48, 28%), identification of fetal heart abnormalities (n46, 22%), and for pain relief (n44, 21%).
Staff told us that transfers had been clinically appropriate and that there had been no occurrences of women inappropriately attending the birthing centre. It was trust policy to report any inappropriate transfers or attendances as incidents using the Datix incident reporting system.

We were told there was ongoing review and monitoring of trends in transfer rates, and any practice issues highlighted would be addressed by the governance midwife and raised in women’s clinical governance, quality, and performance meeting agendas.

From July 2017 to June 2018 there were 98 women booked for home births with the Pontefract and Wakefield community teams. Of these, 33 women (34%) were transferred to Pinderfields Hospital for delivery.

From July 2017 to June 2018 there were 13 women booked for home births with the Dewsbury community team. Of these, 2 women (15%) were transferred to Pinderfields for delivery.
Competent staff

Matrons and managers monitored staff training monthly. They allocated staff to training and used the appraisal system to identify the need for additional training.

Appraisal rates

Following our inspection, the trust provided appraisal data for staff within maternity services. Data showed that as of June 2018, 100% (all) of 417 eligible maternity services staff at the trust had received an appraisal.

Following the change in legislation, (April 2017) the statutory role of the supervisor of midwifery (SOM) no longer existed. The service had implemented a role called midwifery advisors. Midwifery advisors were on call for 24 hours for independent advice and support as required.

Midwifery staff we spoke did not report any problems accessing midwifery advisors for supervision, guidance and advice. However, we did see that the ratio of senior midwives to midwives at the trust was low compared to the national average. From January 2017 to December 2017, the ratio of senior midwives to midwives at the trust was 0.13; this was considerably lower the national average of 0.24.

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017 - March 2018’ paper was submitted to the Trust Board in June 2018. The paper outlined that the service is currently working on a project to develop the midwifery support workers’ (health care assistants) skills set. This will involve a new job description, competency packages and reconfiguration of allocation into certain clinical areas to support the delivery of safe care.

The paper detailed that skill mixing is essential to ensure midwives are effectively deployed and supported by other colleagues, such as maternity support workers who are giving clinical care. In addition, that current data and the consensus of expert midwifery opinion is that a 90% to 10% split between midwives and non-midwifery support staff allows for flexible and sustainable services. At the trust, the proposed skill mix adjustment is based on support staff replacing midwifery hours only in postnatal services.

Band 5 staff had a structured programme of rotation as part of their preceptorship programme. The midwifery preceptorship programme provided key consolidation areas for all midwives to become confident in implementing their role in the rotation programme. This ran over a full two year period. Staff spent six months on the antenatal and postnatal wards, six months at the delivery suite, three months in the along-side birth centre (all at Pinderfields Hospital), and nine months in a community placement in any of the three trust locations.

To maintain skills and confidence, band 6 ‘core’ midwives were rotated on a short ‘up-date rotation’ for three months into the labour suite. This followed from staff feedback, that being called to the main obstetric unit caused some apprehension.

Community midwives rotated into the labour suite for two weeks each year; to help keep up their competencies. This commenced in June 2018. We saw that midwives from each of the three community teams at the trust had either had staff rotate into the service, or were rostered to do so.

Senior staff reported that any member of maternity staff can request to rotate to another area, and this was facilitated by the Maternity Matron.

The service offered a postnatal discharge lounge at the location, and a new born and infant physical examination (NIPE) clinic; staffed by NIPE trained midwives. In addition to this, the service reported that three triage midwives and six birth centre midwives were NIPE trained.

Across the service, 24 community midwives were NIPE trained (nine in the Dewsbury team, seven in the Wakefield team, and eight in the Pontefract team).
The trust was unable to provide bereavement training completion rates for maternity services staff. They reported that processes were in place to ensure the data is captured going forward, as part of the service’s mandatory training for midwives’ update. We saw evidence of a programme of upcoming training sessions, and a schedule for all midwifery and nursing staff in the service to be trained in the next three years. Bi-annual maternity specific study days were also available (see Caring, emotional support section).

We saw that ward midwives in inpatient areas used PURPOSE-T, a toll used for risk assessment of pressure ulcers. Midwives reported they had received training to use the tool. This was identified as an area of good practice.

**Multidisciplinary working**

There was a formalised structure of meetings in place to enable multidisciplinary team working. These included monthly maternity governance meetings and perinatal mortality and morbidity meetings.

We observed good multidisciplinary working in clinical areas. All staff, including those in different teams and services, were involved in assessing, planning and delivering women’s care and treatment.

Multidisciplinary ward rounds took place each morning and evening for all women and review of critical care women as their condition dictated. The labour ward coordinator also took part in the medical handovers. Anaesthetists took part in the morning medical handover.

The service participated in regional and local multidisciplinary team networks, in areas such as fetal medicine.

We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.

Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists, and pharmacy.

Midwives at the hospital and in the community worked closely with the trust safeguarding team, GPs, and social care services, when dealing with safeguarding concerns or child protection risks.

Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals when needed.

There were clear processes in place for multidisciplinary working in the event of maternal transfer by ambulance from homebirth to hospital.

Emergency training (YMET) and skills and drills training included multidisciplinary staff.

In addition, mandatory bereavement training study days were available to all maternity, neonatal, gynaecology and obstetrics staff. Staff from A&E were recently invited to attend the sessions, to assist them with women attending with a fetal loss within their department.

**Seven-day services**

The triage, labour ward and birth centre offered a 24/7, seven days a week service.

There was medical staff presence on the labour ward and triage unit 24 hours a day, with consultant presence 15 hours a day Monday to Friday (08:00 to 23:00) and 11.5 hours a day Saturday and Sunday (08:00 to 19:30).
An obstetric theatre team was staffed and always available. Anaesthetic cover was provided on the delivery suite 24 hours a day, seven days a week, and included an epidural service.

On-call community midwives were available twenty-four hours a day, seven days a week.

Since our last inspection in May 2017, the antenatal day unit had extended opening hours to 07.30am to 8.00pm Monday to Friday.

The service had also introduced a new born and infant physical examination (NIPE) clinic, with administrative support; which ran seven days a week. A discharge lounge had recently been introduced, and became fully operational in July 2018.

**Health promotion**

There was a lead midwife for public health at the trust.

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in infant feeding, substance misuse, diabetes, and perinatal mental health.

Trust-wide maternity dashboard data showed that from July 2017 to June 2018, the proportion of women smoking at time of booking was 19.7%, and the proportion of women smoking at time of delivery was 15.8% (which was within the trust target of 18.3%).

Yorkshire and Humber maternity dashboard data for the period April 2017 to December 2017 showed the proportion of women smoking at time of delivery ranged between 15.8% to 20.7% per quarter at the trust (mean 17.7%). This was worse than Yorkshire and Humber averages for the period, which ranged from 13.4% to 13.6% per quarter (mean 13.5%).

A smoking cessation lead midwife had recently been appointed to improve smoking at time of delivery rates for pregnant women within the Wakefield locality. The role included empowering staff to assist women to stop smoking during pregnancy. We saw that new pathways for smoking in pregnancy had been ratified at the February 2018 maternity governance meeting.

A range of health promotion patient information leaflets was available at the service. These included, immunisation in pregnancy guidance by Public Health England, ‘Why weight in pregnancy matters’, UNICEF ‘Building a happy baby: A guide for parents’, and a guide for management of long term health conditions in pregnancy. A selection of smoking cessation material was also on display.

Pregnant women were able to take advantage of 10 free (‘pregnant tums and new mums’) swimming sessions, at various locations across in the local area.

Information about antenatal classes and support groups were also displayed. These included a free six-session ‘Nurturing parents – preparation for parenthood’ course.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 95% for completion of level 1 (core) Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) mandatory training, and 85% for level 2 (role specific) MCA and DoLS mandatory training.
Trust level

A breakdown of compliance for MCA and DoLS mandatory training courses for applicable staff in maternity services at the trust as of June 2018 were provided.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA and DoLS Level 1</td>
<td>449</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>MCA and DoLS Level 2</td>
<td>186</td>
<td>251</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>MCA and DoLS Level 3</td>
<td>26</td>
<td>44</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the completion target for MCA and DoLS Level 1 training (100%), but did not meet completion targets for MCA and DoLS Level 2 (74%) and Level 3 (59%) training.

Women we spoke with confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.

Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with DoH consent to treatment guidelines.

Staff we spoke with clearly articulated consent procedures, and the use of Gillick competency for consent of patients under the age of 16 years.

We saw that ‘Consent to examination or treatment’ patient information leaflets were available in clinical areas.

Is the service caring?

Compassionate care

Friends and Family test (FFT) performance

Friends and family test performance (antenatal), The Mid Yorkshire Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

The trust performance dropped slightly to 92% in September 2017, compared to the England average of 97%. The trust performance for antenatal in the latest month, March 2018 was 97%, the same as the England average, 97%.
Friends and family test performance (birth), The Mid Yorkshire Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Each pair of lines below is for each month, the top number is the England Score, the bottom number is the Trust Score.

The trust performance (% recommended) for birth services in the latest month, March 2018 was 100%, compared to the England average of 97%.

Friends and family test performance (postnatal ward), The Mid Yorkshire Hospitals NHS Trust

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to England average.

The trust performance improved and was higher than the England average in April 2017. Performance was similar to the England average during May 2017 and then dropped below the England average between June and August 2017. Performance then remained similar to the England average between September 2017 and March 2018; with the exception of December 2017, when the trust dropped below the England average.

Friends and family test performance (postnatal community), The Mid Yorkshire Hospitals NHS Trust
From March 2017 to March 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The trust performed similar to other trusts for 12 out of 16 questions in the CQC maternity survey 2017; two questions were not applicable to responses gained about maternity services at the trust.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.59</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.08</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.50</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.94</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.08</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.20</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.71</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.74</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.40</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.12</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.97</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the</td>
<td>7.61</td>
<td>About the same</td>
</tr>
<tr>
<td>Information or explanations you needed?</td>
<td>Same</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.04</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>7.89</td>
<td>Worst performing trusts</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Data suggested a mixed picture of antenatal and (hospital) postnatal care at the service in the 12 to 18 months prior to our inspection. We saw evidence that the service was using data described below to help drive improvements in patient experiences of care. For example, following CCG and MVP maternity survey feedback, the trust’s maternity service had planned an ‘always event’ workshop for September 2018. The service planned to implement a ‘15 steps challenge’ (NHS England) review of services, and there was also a maternity services improvement plan in place (see Well-led, engagement and learning sections).

In the CQC maternity survey, the trust performed worse than most other trusts for treating women with kindness and understanding in hospital after the birth of their baby. In addition, FFT data from March 2017 to March 2018 showed postnatal ward performance (% recommended) was variable; and dropped below the England average for four of the months.

A recent survey of maternity service users was commissioned by the CCG in conjunction with the Maternity Voices Partnership (MVP) group. Data was gathered from 502 women in early 2018. The survey focussed on postnatal care, but many women shared their experiences of their entire maternity journey.

Throughout the survey, there were many positive comments about staff, care and feeding support received whilst in hospital. For example, when asked what was good about their experience, comments included, “1:1 care from midwife”, “fantastic/supportive / friendly care from midwife” and “kept well informed”.

In addition, quantitative data was largely positive. For example, on a scale of 1 to 10 with 10 being excellent, 75% of women rated their maternity experience overall as 6 or above; and 26% rated it as a 10.

However, there were also a number of negative comments (n62, 12%) around staff attitude, consistency of staff, quality of care, feeding support, lack of information and support. Delays in discharge, induction and triage were also areas for improvement raised.

When considering the data, it is important to note that CQC maternity survey data was gathered from women who gave birth in January to February 2017. In addition, FFT postnatal ward performance (% recommended) was generally similar to England average across the period measured. In April 2017 it exceeded the England average.

CCG survey data was gathered from women in early 2018, in conjunction with the Maternity Voices Partnership (MVP) group. Membership criteria for the MVP included having given birth at the trust in the last four years. Summary data showed that the experience of women who had given birth in the last 12 months (post reconfiguration) was rated slightly higher than for women who had given birth 12-24 months previously. However, we were unable to directly access the data to determine the extent to which patient ratings had improved pre and post reconfiguration of services (September 2016). In addition, we were unable to gauge the extent to which women’s expressed concerns captured experiences of care since our last inspection of the service.
At our recent inspection we identified some evidence to suggest that women were not always provided with compassionate care. This predominantly related to postnatal (hospital) care.

Following the inspection, the trust provided ‘Plus 5’ maternity reports, which asked questions based on feedback from an ‘always event’ held with women 2017. Questions had been added to FFT cards. From February to April 2018, data showed 17% to 13% of women receiving hospital postnatal care did not agree they were always treated with kindness and understanding.

We also received some direct feedback from maternity service users earlier in 2018, prior to our inspection, who described poor experiences of postnatal (hospital) care.

However, during our recent inspection, we spoke with three postnatal women (and their partners) who voluntarily expressed that they had a “good” experience, and had “no complaints”. We spoke with a couple who had previously had a baby at the trust pre-reconfiguration of maternity services. They described that the standard of care was “much better than last time” and it was “previously very disrespectful”. This time, they commented that they were “treated as a family unit”, the care had been “brilliant” and they had received “all the help needed”.

From February to April 2018, data from ‘Plus 5’ responses suggested women using antenatal and birth services experienced good standards of compassionate care. For example, women were asked if they were always treated with respect and dignity. In antenatal services, responses ranged from 97% to 98%. In labour and birth services responses ranged from 98% to 100%.

During our visit, we spoke with two women who were antenatal inpatients. Both were happy with the care received. One of the women had been initially assessed in triage, and reported she was “straight to triage … seen straight away”. It was noted, that the antenatal ward staff were “amazing” and “lovely”, but that the environment was “busier this side”.

We also spoke to two women in the induction of labour suite. The women expressed they had received “good care”, but we noted that one of the women had been awaiting induction since the previous day.

Overall, the evidence gathered suggested that when women (and their families) experienced poor quality care in other areas of the service, this often related to recognised pressures in antenatal clinics and day units, triage and induction of labour (see Responsive, access and flow section). Similarly, waiting times and delays for triage, induction, and (outpatient) antenatal services experienced in the service were reflected in patients’ complaints and concerns (see Responsive, learning from complaints and concerns section).

The senior management team, and staff we spoke with in antenatal (including triage) areas and (hospital) post-natal areas recognised that capacity pressures (such as waiting times and delays) sometimes negatively affected women’s experiences of care.

Despite the pressures, staff told us they were positive about providing good quality and compassionate care to women.

In all areas of the maternity service visited during our inspection we observed staff interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.

**Emotional support**

There were guidelines and care pathways in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.

The trust had a named maternity bereavement midwife. In addition to providing bereavement training, the role included providing advice, training and support to staff caring for and supporting bereaved parents within the service.
A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss. The bereavement midwife worked collaboratively with the consultant lead, to ensure women received appropriate support following pregnancy loss.

The trust was unable to provide bereavement training completion rates for maternity services staff. They reported that processes were in place to ensure the data is captured going forward, as part of the service’s mandatory training for midwives update.

The service reported that, from June 2018, the maternity bereavement training session had been included within the midwives mandatory training update (with 25 training spaces offered every month). As recommended by Yorkshire & Humber and Stillbirth and Neonatal Death Support (SaNDS), training was required every three years. The service said that the training programme and schedule would ensure that all midwifery and nursing staff were up to date with the now mandatory requirement within the next year.

In addition to mandatory bereavement training, staff were able to attend bespoke maternity bereavement study days; which took place every six months. At the time of inspection, we saw one study day had taken place so far in 2018, with a further two planned later in the year. Study days could accommodate 15 to 20 participants, and were available to all maternity, neonatal, gynaecology and obstetrics staff. Staff from A&E were recently invited to attend the sessions, to assist them with women attending with a fetal loss within their department.

Senior staff told us that funding was available for staff wishing to attend further external training, that included obtaining consent for post-mortem examinations.

The multi-faith chaplaincy service offered bereavement support to those who have lost a baby through miscarriage, stillbirth or neonatal death; and had a 24-hour on-call service including out-of-hours cover for emergencies via hospital switchboards.

There was a perinatal lead midwife in the service, who had been appointed to improve services for vulnerable women and those with perinatal mental health concerns.

Staff said perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.

A survey of maternity service users was commissioned by the CCG in conjunction with the Maternity Voices Partnership (MVP) group (see Compassionate care section, above). The summary information received noted negative comments that included those around lack of support. As previously described, we were unable to gauge the extent to which women’s expressed concerns captured experiences of care since our last inspection of the service.

The service scored similarly to other trusts for questions in the 2017 CQC maternity survey that related to support. For example, for the question, “at the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?”.

During our recent inspection, we spoke with seven women at the service and none identified concerns around a lack of support; and several spontaneously described that they felt “supported” by staff.

However, we did identify some concerns around postnatal (hospital) support. Our concerns about the standards of care provided on postnatal wards include information described above (see, Compassionate care section) and below (see Understanding and involvement section). In addition, from February to April 2018, data from ‘Plus 5’ responses showed 42% to 12% of postnatal women on wards did not agree they always received support and encouragement about breast feeding.

**Understanding and involvement of patients and those close to them**
Women were given the opportunity of making an informed choice about all available birth settings appropriate and safe for their clinical need and risk.

There were guidelines for standalone and along-side birth centres, and for homebirths. These provided guidance on which women were eligible for midwifery led care, risk assessments and record keeping, and actions to take should the woman develop risk factors requiring obstetric opinion.

Lower risk women were able to deliver in any of the birthing suites provided by the service, and in their own homes; and could also opt to deliver at the labour ward if they so wished.

There was a Maternity Voices Partnership (MVP) group in place at the trust. Women who are pregnant or have had a baby in the last four years can meet together with staff from the maternity services. This included midwives, obstetricians, breast feeding peer supporters, and staff from the Clinical Commissioning Group (CCG) who commission services on behalf of local people.

Over the past year the MPV had discussed the re-configuration of maternity services and received presentations from Homestart family charity, PANDAS (Pre and Postnatal Depression Advice and Support) and the trust Matron for Children who discussed care from health visitors and wider children’s services.

A survey of maternity service users was commissioned by the CCG in conjunction with the MPV group (see Compassionate care section). The summary information received noted negative comments that included those around lack of information. As previously described, we were unable to gauge the extent to which women’s expressed concerns captured experiences of care since our last inspection of the service.

In the CQC maternity survey 2017, maternity services at the trust were among the best performing for speaking to women in a way they could understand during labour and birth. Responses to several other questions pertaining to offering information and inclusion in decision-making were similar to other trusts.

During our recent inspection, we spoke with seven women and their partners at the service. Many volunteered descriptions about receiving good information and advice, and feeling they had been involved in decision-making. They described they had been “supported to answer questions”, “doctors explained well”, staff “answered all questions”, staff were “good with explaining things”, have “been involved”, and they had “questions answered, [and] feel an equal part of care”.

From February to April 2018, data from ‘Plus 5’ responses suggested women using antenatal and birth services experienced good understanding of and involvement in their care. For example, women were asked if they were always given time to ask questions or discuss pregnancy in antenatal services, and an average of 93% agreed they had. Over the same period, 93% to 95% agreed they were always spoken to in an understandable way. In labour and birth services, 93% to 95% of women agreed that they were always involved in decisions about their care, and 98% to 100% agreed they always had concerns raised taken seriously.

However, over the same period, only 73% to 81% of women receiving hospital postnatal care agreed they were always given the information or explanations needed. In addition, only 80% to 84% agreed they always felt listened to by the midwives seen.

Following CCG and MVP maternity survey feedback, the trust’s maternity service have planned an ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. The event will bring together new mothers and staff with the aim of improving the experience of women using its maternity services. Senior staff also told us that findings from the ‘always event’ workshop would be used to refresh the maternity services patient experience action plan.
Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From June 2016 to December 2017 the bed occupancy levels for maternity were generally higher than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

From July 2017 to June 2018, there were 5,748 deliveries were at Pinderfields Hospital. There were 4,856 deliveries at Pinderfields hospital labour suite (an average of 13.3 deliveries per day), and 892 deliveries at Pinderfields midwifery-led birth centre (an average of 2.4 deliveries per day).

Data provided by the trust showed from July 2017 to June 2018 the average bed occupancy rate was 81% on the labour ward, and 36% at the birth centre. Data followed DoH (KH03) definitions, which means an occupied bed day is defined as one which is occupied at midnight on the day in question.

The maternity service at Pinderfields Hospital provided both consultant-led and midwifery-led care via an antenatal service (including pregnancy screening clinics, and an antenatal day unit, and maternity triage), a labour ward, inpatient antenatal and postnatal wards, and an alongside midwifery-led birthing centre. The premises and facilities were appropriate for the services provided there.

Women whose pregnancies were low-risk were able to choose to deliver at home, in the midwifery-led birthing centre, or in the labour ward.

The population served by Pinderfields Hospital was culturally and ethnically diverse, and women attending the hospital and birthing centre during our inspection were from a variety of
backgrounds. None of the women we spoke with expressed any concern about staff understanding of their personal, cultural, social, or religious needs.

The lead perinatal midwife carried a caseload of women within HMP Newall, and worked with women and prison staff to provide continuity of care whilst developing pathways to improve service provisions.

Partners were encouraged to stay in the birthing centre with mothers and babies following delivery, until discharge. There was a postnatal room with a double bed for mothers and their partners.

Overnight visiting was restricted on the hospital wards to those accompanying women whose clinical/social circumstances suggested a particular need, in order to lessen impact on other patients.

Community-based maternity services were provided from a number of locations within the area; predominantly in GPs’ surgeries, children's centres, and women's own homes.

Meeting people’s individual needs

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in safeguarding, perinatal mental health, bereavement, diabetes, twins (multiple pregnancy), and infant feeding.

The service also employed a teenage pregnancy midwife, who specialised in supporting pregnant women under 20 years of age.

The trust offered a range of spiritual and holistic healthcare services at each site. The trust’s chaplaincy team offered a point of contact with the appropriate faith community, and there was a multi-faith centre, hospital chapel and prayer rooms on site. The chaplaincy service was available to visit wards/units to meet with patients, carers, and staff; and an out of hours service was available.

Funeral options were offered within maternity services following a pregnancy loss, and the trust had a protocol to offer joint cremation or burial for babies/fetuses lost up to 24 weeks gestation. An allowance was made for Islamic communities or any other individual who choose to have individual burial, if they so wished.

Face-to-face foreign language interpretation services were provided by Kirklees Council. Telephone based interpreting services were provided by ‘BigWord’; who also provided translations of written documents into either audio or written format. British Sign Language (BSL) services were also available.

We saw several maternity service patient information leaflets were available in a variety of languages on the trust’s internet pages.

The trust had been working with an external company to establish feedback mechanisms which supported access for harder to reach groups. FFT cards were available in large print on yellow card and easy to read versions. A freephone interpretation service could be accessed for feedback in many languages and translated versions of the survey were also available via the trust website. Interpreters, accessed via the trust, had been given written information to support the verbal translation of feedback from patients they saw.

The trust access group met quarterly with stakeholders with disabilities to identify and improve services. Specialist learning disabilities nurses were available at the trust, who led a learning disability patient experience group.
Access and flow

At inspection, we identified significant access and flow issues around antenatal clinic and day unit capacity, triage waiting times, and induction of labour delays. We also noted four whole service closures had occurred between June 2017 and July 2018.

Antenatal services

Trust-wide maternity dashboard data showed that from July 2017 to June 2018, 92.7% of initial antenatal bookings were undertaken before 13 weeks. This was above the trust target of 90%.

However, staff in antenatal clinics and antenatal day units (across sites) told us that they experienced difficulty offering women follow-on clinic, and review appointments due to increased demand and limited capacity.

During our inspection, staff showed us a capacity list of over 150 women waiting to be booked for antenatal follow-up appointments across the service, and we saw no additional slots were currently available until October 2018.

We also saw evidence of long waiting times in antenatal clinics on FFT responses. For example, in March a lady commented “appointments (always running late)”. In April 2018, one woman expressed, “waiting times long, no communication about delays”. In May 2018, another described “today’s waiting time is too long”.

Senior management we spoke with recognised the high demand for antenatal appointments at the location, and across maternity service sites. As of April 2018, three entries on the maternity risk register identified moderate to high risks in relation to antenatal clinic capacity, the availability and capacity of obstetric staff for clinics/review, and increased demand for scan requests.

The management team and senior staff described the implementation of several actions to try and improve access and flow across the antenatal service (which were noted on relevant maternity risk register entries). These included training two midwifery sonographers, extending the antenatal day unit opening hours at the Pinderfields site, development of a midwifery care pathway for scanning and scan review, and an antenatal booking and risk assessment audit (the latter is due to be completed August 2018).

The management team explained flexibility had been introduced within the antenatal service, by directing low risk women to midwifery-led day units (Pontefract and Dewsbury) where possible. On-call obstetric consultants were able to review CTG results remotely, and we saw evidence of this during our visit.

There was also an antenatal clinic task and finish group in place at the service, and we reviewed an action log compiled by the group dated to July 2018. The log detailed 39 actions, 32 of which were completed, and five were in progress. Ongoing actions included setting up a sub-group to agree a diabetic pathway and improvements to the antenatal clinic booking system. We saw that outstanding actions were due to be completed by August to September 2018.

An antenatal clinic summit was being organised for September 2018 to review ideas for rapid resolution across the antenatal service.

Information received from the trust following the inspection showed that the concerns with insufficient antenatal clinic capacity to meet the volume of patients was due to insufficient medical staff to cover the antenatal clinics. This resulted in 150 women at the time of inspection and across the trust, waiting for an antenatal appointment. Antenatal clinic capacity was recorded on the trust risk register and identified as a priority.

From the 1st August 2018, the situation improved with the new intake of doctors. The gaps on the rotas had reduced and extra capacity clinics had been opened to accommodate the volume of patients. This meant that although there were 28 patients awaiting an appointment (as of mid-
September 2018), processes were in place for these patients to be seen within the required timeframe. We saw that the ‘capacity list’ was monitored on a daily basis. Patients who could not be booked for a further appointment due to clinic capacity, were escalated to the antenatal clinic lead consultant. They reviewed the individual patient records and agree a suitable date for the women to be seen; without impact to their care. As of September 2018, we were assured that all patients had been seen within the appropriate timescale. However, should this not be possible, that a formal risk assessment would be undertaken and documented. This had not been required to date.

**Triage**

Women were able to access triage and delivery services at a time to suit them. Triage, labour ward and birth centre services at the site were available 24 hour a day, seven days a week.

However, senior management and ward staff reported that waiting times and patient flow in triage was a common challenge. Ward staff said that the majority of complaints received about triage related to waiting times and delayed discharge.

Earlier in 2018, some maternity service users had contacted Healthwatch to express their concerns. Two of the complaints appeared to relate to triage, and suggested the unit was busy with too few staff/beds available. One woman expressed that she had arrived at 7pm, she was then monitored, and “the rest of the time … was just sat in a corridor waiting”. She reported leaving at 2am. She noted that, “there were pregnant women sat on the floor as there were not enough chairs. Other women were having contractions, holding onto the wall in pain as there were no beds. It was awful”.

To help improve waiting times and patient flow, the triage service had introduced dedicated junior doctor (staff grade two) cover from Monday to Friday, 8.00am to 5.00pm; with on-call junior doctor cover outside these hours. We also saw that a patient information board had been added to the waiting area that informed women of current estimated waiting times.

Senior management and ward staff told us that they had started to see a reduction in triage waiting times and delays. However, demand for the service remained high.

The trust reported that from May 2018 to June 2018, 7.6% of women who attended triage experienced a delay in initial midwife review of more than 30 minutes.

During our inspection, we saw that delays in triage were under a task and finish group and labour ward forum review. We also observed an initial-assessment room had been introduced in triage, and was awaiting final signoff for operational use (July 2018). Senior management and ward staff hoped that the room would improve waiting times and delays; and offer a private area for confidential sensitive consultation.

**Induction of labour**

Delays of planned inductions of labour was rated as presenting a high risk on the maternity risk register. The monthly maternity clinical governance report (May 2018) rated this as the highest risk facing the service; and the senior management team and governance midwife highlighted induction of labour delays as a significant concern.

The service had introduced an eight-bed induction suite post-reconfiguration of maternity services (2016), to help coordinate and manage the number of inductions by risk and capacity limits. In addition, induction of labour admission standard operating procedures had been revised to better manage patient flow. During our recent inspection, we saw that delayed induction processes were under a task and finish group and labour ward forum review. We observed that induction delays were among the highest reported of red flag indicators at the service. This was also reflected in the maternity risk register, and in maternity clinical governance meeting minutes (December 2017 to June 2018).
Data for delays in planned artificial rupture of membranes (ARM) showed that from July 2017 to June 2018, 1367 ARM delays were recorded. The number of ARM delays recorded related to data captured at four-hourly intervals, and did not relate to individual women who had experienced a delay. At the time of inspection, the service did not record the number of individual women who experienced an ARM delay, and could not, therefore, provide a delay rate percentage.

The service noted that work was undertaken through a task and finish group, which identified some ARM delays were not acted on until the 24-hour red flag. It was therefore considered beneficial to remove the >24 hour time period, and measure women from the point at which they were considered appropriate for ARM (March 2018). The data presented above spans both data collection methodologies. The service noted that since this step change performance looked as though it has deteriorated, however, the pathway had improved.

Data for delays in planned induction of labour (IoL) showed that from July 2017 to June 2018, 511 IoL delays were recorded of 24 hours or more. The number of IoL delays recorded related to data captured at four-hourly intervals, and did not relate to individual women who had experienced a delay. At the time of inspection, the service did not record the number of individual women who experienced an IoL delay, and could not, therefore, provide a delay rate percentage.

Nice red flag guidance (Safe Midwifery Staffing for Maternity Services, 2015) recommends recording where there is a delay of 2 hours or more between coming in for an induction and the induction being started. It is considered that IoL delays would be considerably higher at the service if NICE methodology was used.

In the monthly maternity clinical governance report (May 2018) it was recognised that there were additional NICE red flag indicators not currently in use, and consideration could be given to those and other locally agreed figures.

Since our last inspection of the service, the task and finish group had commissioned a small snap shot study into reasons for ARM delays, to determine if delays were due to staffing or capacity. The study found that 50% of all ARM in a two-week period were performed after a 24-hour delay had occurred. The most frequent reason (45%) that women were not transferred for ARM was, despite being fully staffed, there were no available midwives to assign care to. The study found that this was not linked with full capacity of intrapartum beds. Findings indicated that there was space on the delivery suite, but not enough midwives despite establishment being met. There were 13 intrapartum beds, with eight midwives rostered to deliver one-to-one care in labour.

The senior management team described that demand for inductions had increased and continued to increase, following changes to NICE guidance (for example, in line with guidance about larger for gestational age babies). They also acknowledged that the induction rate at the service was high (maternity dashboard data showed that from July 2017 to June 2018, the induction of labour rate was 34.3% at trust level, and 38.0% at the location, see Patient outcome section).

Senior management explained that given midwifery staffing indicators were being met (see Midwifery and nurse staffing section), this indicated the problem lay with the deployment of staff to different service areas – rather than the number of staff within the service. They said a rapid improvement process workshop was planned for September 2018, to examine the effective redeployment of rotational midwifery staff. An induction of labour booking process audit of 59 who attended triage for a CTG due to delayed IOL, or who were awaiting ARM or augmentation for prolonged SROM at home was in progress.

Senior management described measures to reduce the induction rate, which included seeking advice from an external provider to implement new CTG methods to safely reduce inappropriate triggers for induction.

Closures

The service had an Escalation and Closure Policy (review date August 2019). The policy provided guidance for maternity staff about clinical decision making and required actions in the event of a
closure. This is a situation where capacity and complexity of workload present challenges in the delivery of a safe maternity service for women and their babies, and the service must be closed to new patients. It stated that closure would only be considered when all other potential solutions were exhausted.

The trust provided data that showed the number of closures at the service from July 2017 to June 2018. Data showed full site closures had occurred on four separate occasions in July 2017 (4 hours 51 minutes), December 2017 (10 hours, 40 minutes), February 2018 (5 hours, 30 minutes), and May 2018 (9 hours, 49 minutes); these included closures of the labour ward and alongside midwifery unit at the location.

While an executive decision, we saw some whole maternity service closures had been reported to the trust board. For example, the closure in December 2017 featured in the February 2018 board paper. Where discussed, whole service closures had occurred because of the number of women giving birth and the lack of beds available (as opposed to staff shortages). When labour ward closures occurred, women were redirected to the nearest maternity unit with capacity to where they lived.

Learning from complaints and concerns

There was a trust complaints policy and procedure in place, which staff we spoke with were aware of.

We observed patient advice and liaison service (PALS) information leaflets on display in the areas we visited.

We also saw trust information leaflets on display in the waiting area about how to make a comment, compliment or complaint.

Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform their manager.

Summary of complaints

From April 2017 to February 2018, there were 88 complaints about maternity services. The trust took an average of 20.4 days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be closed within 30 days.

Of the 88 complaints received about maternity services, 74 related to maternity services at Pinderfields Hospital.

Most of these 74 complaints related to care provided on the labour ward (n26, 35%), and the PACU, triage, and birth centre (n21, 28%). The remainder were made about inpatient antenatal, postnatal and transitional care services (n14, 19%), and antenatal clinic and day unit services (n13, 18%). No complaints were received about community midwifery services.

<table>
<thead>
<tr>
<th>Pinderfields Hospital</th>
<th>Antenatal Clinics/Day Unit</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Midwives</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Antenatal, Postnatal, Transitional Care</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Labour Suite</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>PACU and Triage</td>
<td>21</td>
</tr>
</tbody>
</table>

74
Number of compliments made to the trust

From April 2017 to February 2018, there were 127 compliments were received and recorded about maternity services.

Of these, 43 (34%) were made in relation to maternity services at Pinderfields Hospital. Most of the 43 compliments received were about care provided the labour ward (n19, 44%) and by community midwives (n18, 41%).

<table>
<thead>
<tr>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Antenatal Clinic</td>
<td>4</td>
</tr>
<tr>
<td>Community Midwives</td>
<td>18</td>
</tr>
<tr>
<td>Antenatal, Postnatal, Transitional Care</td>
<td>2</td>
</tr>
<tr>
<td>Labour Suite</td>
<td>19</td>
</tr>
<tr>
<td>PACU and Triage</td>
<td>1</td>
</tr>
</tbody>
</table>

Waiting times and delays for triage, induction, and antenatal services experienced in the service were reflected in patient complaints and concerns. At trust level, of the 88 complaints received by the service from April 2017 to February 2018, many (over 45%) related to care provided in triage and antenatal inpatient/clinic/day unit areas across the service.

The monthly maternity clinical governance report (May 2018) detailed that nine complaints were closed in April 2018. Of these, we saw three related to delays in induction or waiting to be seen in the triage area, all three complaints were upheld. Apologies and explanations for delays had been offered.

A survey of women’s experiences was commissioned by the CCG and facilitated by the MPV group also highlighted delays in induction and triage as areas of improvement.

The service had implemented several actions to try and minimise induction and triage delays and improve antenatal service capacity and waiting times (as described in the Access and Flow section, above). However, the management team and senior staff recognised further improvements needed to be made to improve women’s experiences of these services. We saw that a patient information board had been added to the triage waiting area to inform women of current estimated waiting times.

We saw evidence of learning from complaints and concerns in other service areas. In response to (more historic) concerns about discharge delays on FFT comments, the service had introduced a new-born and infant physical examination (NIPE) clinic since our last inspection, supported by a ward clerk. This was offered seven days per week. Following ratification of a SOP, a separate discharge lounge had recently been introduced at the location, and became fully operational in July 2018.

The service had also introduced a self-medication service; and provided self-medication lockers so women could self-medicate. The patient-led self-medication service was implemented in November 2017 on Gate 18, the antenatal and postnatal ward, and on the elective caesarean section recovery ward. Senior staff also informed us that the project had improved appropriate and timely administration of medication. In addition, it had also reduced discharge waiting times for take home medications, as these were dispensed as in-patient medication for continued use at home.

In the birthing centre we saw that three additional midwives were being NIPE trained to support quicker discharge.
In response to FFT feedback, each inpatient ward area across the service had produced a ‘welcome to the ward’ leaflet that outlined meal times, discharge procedures, telephone numbers and ward information (completed October 2017 and updated March 2018). We saw these on display during our visit.

There was a Maternity services patient experience action plan 2018/2019. The plan listed 17 actions informed by patient feedback, designed to improve patient experience. We saw 14 actions had been completed, one action had been removed, and two actions were ongoing.

Following CCG and MVP maternity survey feedback, the service had planned an ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. Senior staff also told us that findings from the ‘always event’ workshop would be used to refresh the maternity services patient experience action plan.

Is the service well-led?

Leadership

Maternity services formed part of Family Services and Clinical Support division. A head of clinical service for obstetrics and gynaecology, a patient services manager, and an interim head of midwifery (IHOM) led the maternity service.

The senior management team had changed since our previous inspection in May 2017, and was relatively new. At the time of our most recent inspection, the head of clinical services had been in post for eight months, and the IHOM had been in post for seven months.

The management team described that they had started to make ‘in roads’ into the service, and to implement the changes necessary to improve quality of care. During our inspection, we observed cohesive team working; with support offered from clinical leads and the deputy director of operations (Families and Clinical Support Services).

Managerial staff we spoke with told us the IHOM was visible and engaged, and ward staff reported they were supported by their managers. Many of the managers we spoke with undertook clinical shifts, to support teams and keep their competencies up to date. For example, the triage and birth centre manager worked one shift on the triage and one at the birth centre per week. Staff we spoke with informed us the matrons worked clinically if needed.

There were two band seven community midwifery team leaders at the service. One responsible for the Pontefract community team and Wakefield community team, and one responsible for the Dewsbury community team.

Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme and through one-to-one meetings with managers.

Vision and strategy

The trust’s vision was “to achieve an excellent patient experience each and every time”.

There was a maternity governance and risk management pathway (review date July 2020); which stated that the aim of the maternity service was “to provide all our women and babies with high quality care that is delivered in a safe environment”.

The trust had a maternity service improvement plan (March 2018), designed around high-level themes the service aspired to achieve. Themes centred on building strong leadership, building the capability and skills of staff, sharing progress and lessons learnt, and improving data capture and
knowledge. A multidisciplinary meeting identified five focus areas to improve safety within the maternity service; leadership and teamwork, staff training and development, clinical governance, perinatal mental health, and ensuring quality maternity data. There was an action plan for each core focus area, which detailed the recommendation, actions implemented to achieve it, designated lead, and evidence of implementation. At the time of viewing, all but one of the actions (which was ongoing) had been completed; but during our inspection several areas of the maternity service (especially in relation to access and flow) were identified as in need of quality improvements, with no clear strategy in place to address these issues.

There was a maternity services patient experience action plan 2018/2019. The plan listed 17 actions informed by patient feedback, designed to improve patient experience. We saw 14 actions had been completed, one action had been removed, and two actions were ongoing. An ‘always event’ workshop was planned for September 2018, to bring together new mothers and staff with the aim of improving the experience of women using its maternity services. Senior staff told us feedback from the event would be used to revise and update the patient experience action plan.

We also saw evidence of action plans arising from engagement with maternity services staff at the trust. For example, an action log arising from a ‘little conversation’ event with community midwives earlier in the year.

**Culture**

The Freedom to Speak Up Guardian (FTSUG) submitted six-monthly progress reports to the trust board. In March 2018, the FTSUG report showed that from September 2017 to March 2018, the greatest number of concerns raised from one specific area came from staff within maternity services (seven), both acute and community. We saw that a concern (raised in 2017) included claims of a culture of bullying and cronyism in maternity services. Discussions had taken place between the FTSUG and the Matron and Head of Service for the area concerned.

During our inspection, the IHOM reported that at appointment, she had been given a mandate to focus on the culture within the service.

The IHoM said that she had implemented a programme of ‘little conversations’ to engage with maternity staff, and one had already taken place with community midwifery staff. We saw evidence of an action log arising from the event. Further ‘little conversations’ were planned for birth centre and labour ward staff.

The IHoM said she was approachable and accessible, and welcomed concerns from staff. During our inspection, we observed that the IHoM had visited a member of midwifery staff at another trust site to discuss their concerns.

The IHOM reported that regular meetings took place with Royal College of Midwifery union representatives, to discuss “what happens on the shop floor”.

The IHOM recognised that culture could not be changed “overnight”, but felt that “a corner had been turned”. At the time of inspection, the IHOM told us that she liaised with the FTSUG, and no concerns had been raised by maternity services staff with the guardian since March 2018.

During the inspection we spoke to three junior doctors, on their own. All three individually said that they felt supported by senior obstetric and maternity service staff; and they did not identify any issues in relation to poor culture or patient safety in the maternity service. Some junior doctors expressed frustration about rostering.

At our previous inspection in May 2017, some junior doctors commented that at times, the needs of speciality trainees were prioritised over GP trainee doctors. At our most recent inspection, junior doctors told us there was consultant support for clinical work, but the work allocated did not always
help to meet GP trainee competencies. This, they felt, was due to poor coordination and allocation of trainees.

At our recent inspection, we saw the service had implemented a number of initiatives to improve staff morale.

The service had introduced ‘My Maternity Star’ awards. These allowed staff to nominate maternity colleagues who had made positive contributions to colleagues and patients.

There was also a monthly governance newsletter (“Maternity Measured”), with a more in-depth issue every six months. The March 2018 issue focused on celebrating changes in the 18 months since reconfiguration of the service. The management team thanked staff for their hard work and highlighted achievements and reasons for staff to be proud. Community team leaders and birth centre managers also submitted messages.

We observed strong team working, with medical staff, midwives and theatre staff working cooperatively and with respect for each other’s roles. Most staff spoke positively about the culture at the service, and were proud of the quality of care they delivered.

Some maternity service staff we spoke with during our inspection raised concerns about capacity and workload, which impacted on their perceptions of culture within the service. Concerns predominately related to antenatal service capacity and induction of labour service areas (please refer to Responsive section). Overwhelmingly, staff described feeling “frustrated” about capacity and ‘bottle necks’ in the system.

**Governance**

There was a Maternity Governance and Risk Management Pathway policy document (review date July 2020). The key aims of the pathway were to develop a more dynamic approach to risk management, embed risk management systems and processes and promote a culture where risk management is everybody’s business, and to clearly define roles and responsibilities for risk management and governance at a directorate level.

There was a defined governance structure. There were divisional and obstetric governance leads for the service. The service employed a full-time governance midwife who worked across sites; and a deputy governance midwife was employed two days per week. Staff were aware of their roles and responsibilities in relation to governance.

There were several layers of governance quality assurance. These included the antenatal screening and neonatal screening governance committee, the labour ward forum, maternity governance group, women’s governance group, family and clinical support services divisional governance group, trust quality committee, and trust board.

The maternity governance group met monthly to discuss, monitor and review all aspects of clinical governance. The role of the group was to provide assurance to the divisional governance group, regarding all matters relating to clinical quality and patient safety of the obstetrics and gynaecology services provided by the trust.

The obstetric governance lead and governance midwife led on serious incident root cause analysis (RCA) reports, and worked in conjunction with the matron or manager responsible for the service area.

A quality data and audit midwife had been recruited April 2018. Prior to this, the post had been vacant for more than 12 months. The quality data and audit midwife had oversight of the maternity service audit programme. The governance midwife and IHoM informed us that the quality data and audit midwife had made good progress with backlogs since their appointment, and had prioritised activities for completion. The service reported that activities were on-track to be completed within
adjusted timescales. We saw audit activity was entered on the maternity risk register and this was appropriately monitored and reviewed. However, we noted significant delays with the local maternity audit programme overall.

During our inspection, we reviewed the maternity service RCA action log and found appropriate monitoring and review of actions. There were three outstanding action, but these had been appropriately monitored and an extension granted.

At our last inspection of the service, we found no recommendation of changes to practice in the perinatal mortality and morbidity meeting minutes and actions plans were not completed. Following our recent inspection, we found changes to practice were discussed and recorded; however, we did not see evidence of action plan completion.

Management of risk, issues and performance

There was a Maternity Governance and Risk Management Pathway policy document (review date July 2020). It set out clear guidance for the reporting and monitoring of risk.

Senior staff we spoke with were comfortable escalating issues to the senior management team, and received appropriate feedback. Members of the senior management team were confident escalating issues to the head of women’s services, divisional leads, and (if necessary) directors and the trust board.

The service had a current risk register. This was a live document, comprising of a list of risks, and description summaries, in order of priority. The risk register was generated electronically from the trust’s electronic risk management system (DATIX) and reflected risks placed on the system.

All new maternity risk assessments were discussed on a monthly basis at the maternity risk register meeting and decisions made about the appropriateness of grading, and inclusion. The group also discussed any re-grading or risks which have been resolved from the risk register.

The risks of greatest concerns in relation to clinical and non-clinical issues were monitored by the divisional governance group. Risks that scored 12 and above were reported to the trust patient safety panel and the clinical executive group.

At our previous inspection of the service in May 2017, we saw that the maternity risk register contained a large number of risks, and many had a review date in the past. This led to concern that there was a lack of oversight by senior managers.

At our most recent inspection, we saw good monitoring and oversight of the risk register. Risk register entries were subdivided into risks with ongoing actions, and tolerable risks. We saw evidence of several risks that had been resolved in the past 12 to 18 months. We also saw evidence of appropriate discussion and grading of risks in recent maternity risk register meeting minutes.

The senior management team and senior governance staff were aware of risks facing the service. Antenatal service capacity, delays in triage, and delays in induction of labour were noted as presenting significant concerns. Senior staff recognised that poor performance in these areas impeded good experiences of care for some women. The service had implemented a number of measures to mitigate risks and try to resolve ‘bottle necks’ and increase capacity in these systems; and number of initiatives and improvement workshops were also planned (see Responsive section). The senior management team were relatively new, and we saw they were aware of the issues and had made headway working to address them. However, at the time of inspection, we saw performance in these areas remained limited and negatively affected experiences of care for some women. We saw evidence of an induction of labour task and finish group action log, and an antenatal task and finish group action log. However, we could not be assured that action plans
were robust enough to drive forward the changes necessary to improve quality of care in these service areas in a timely way.

We reviewed an overview of serious incidents, incidents and complaints presented in monthly maternity clinical governance meeting minutes (December 2017 to June 2018). We also saw evidence of more in-depth review of incidents in maternity governance reports. For example, as submitted to the monthly maternity governance committee in May 2018. The report included a summary of incidents, the number, location, and severity of incidents, and incident themes. Comparative data was presented from previous months to map incident numbers, locations and themes over time. Midwifery red flag events were also detailed and thematically mapped. Root cause analyses from previous (completed) investigations were presented, alongside learning from RCAs.

There was a trust-wide maternity dashboard and location specific maternity dashboards (for Pinderfields Hospital, Pontefract Hospital, and Dewsbury and District Hospital). These were discussed at monthly maternity governance meetings. The service submitted data to the Yorkshire and Humber regional maternity dashboard. This meant the service could compare its performance against other local trusts and Yorkshire and Humber averages.

**Information management**

During our inspection, we saw that controlled documents (such as policies and guidelines) were within date, version controlled, and reflected current national guidance.

The service completed comprehensive bi-annual record keeping audits. At the time of inspection, the most recent report available was published December 2017. Audit results were benchmarked against previous findings and targets, and showed areas of improved compliance and areas of concern. Results were categorised using a RAG (red, amber, green) rating system. We saw that an action plan had been put in place to improve compliance. Ongoing activity to monitor changes in compliance included a random sample of eight maternity records per month at each location from January 2018, to be collated for the next record audit report.

During the inspection, we saw three separate entries on the maternity risk register relating to maternity service records; these were rated as presenting a moderate to high risk. All three entries centred around issues with the main maternity record software system. Staff we spoke with during our inspection reported the system was sometimes cumbersome to navigate, but overall, they found the system adequate.

The senior management team were acutely aware of the risks involved, and were currently reviewing options to implement a new paperless system for when the current software license expired (2019). The service had also developed a task and finish group to plan, evaluate and adopt a paperless postnatal record. We reviewed relevant risk register entries and saw that risks had been appropriately monitored and mitigated. We also saw there was an electronic maternity system action plan 2018 in place, which showed progress towards against a new digital maternity plan for the service.

**Engagement**

There was a Maternity Voices Partnership (MVP) group in place at the trust. Women who are pregnant or have had a baby in the last four years could meet together with staff from the maternity services. This included midwives, obstetricians, breast feeding peer supporters, and staff from the Clinical Commissioning Group (CCG) who commission services on behalf of local people.
Over the past year the MPV had discussed the re-configuration of maternity services and received presentations from Homestart family charity, PANDAS (Pre and Postnatal Depression Advice and Support) and the trust Matron for Children who discussed care from health visitors and wider children’s services.

The trust collated and mapped independent/externally collected patient experience data from Picker patient experience surveys and summaries, the NHS patient safety programme, and unannounced ‘walkabouts’ by the CCG. They also produced ‘Plus 5’ maternity reports, which asked questions based on feedback from an ‘always event’ held with women 2017; which had been added to FFT cards.

Following CCG and MVP maternity survey feedback, the trust’s maternity service had planned another ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. The event will bring together new mothers and staff with the aim of improving the experience of women using its maternity services.

The service has also planned to implement a ‘15 steps challenge’ review of services, which will involve service users, commissioners, trust patient experience staff and an executive director. The ‘15 steps’ toolkit was developed by NHS England for MVP groups to help understand what service users experience as they access local maternity care. The toolkit aligns with NHS priorities for maternity care as outlined in the Better Births report published in 2016. The toolkit has been discussed with the local MVP group. Pending ratification at the service’s patient experience sub-committee, the service plans to roll the toolkit out in September 2018.

The service had implemented a programme of “little conversations” to engage with maternity staff, and regular meetings took place between the IHoM and RCM union representatives.

The service had held a rota redesign project looking at all junior doctor rotas earlier in the year.

**Learning, continuous improvement and innovation**

During our inspection, we found a lack of local audit activity to encourage continuous improvement; this had been ongoing since our last inspection of the service.

We reviewed an update to the clinical audit programme and action plan for obstetric and maternity services (dated to July 2018).

We saw that the quality data and audit midwife had made progress with backlogs since their appointment, and had prioritised activities for completion. We also noted that national audit programmes were on-track overall. However, we saw several local audits marked as ongoing that had surpassed dates of estimated completion. For example, the antenatal risk assessment (level 1) audit was due to be completed by March 2017. We also learned that the service had not conducted a MEWS audit in the 12 months prior to our inspection. The service told us this was ongoing and later provided evidence of completion in the form of preliminary data (August 2018); although this had not been quality assured. We could not find evidence in the audit programme that a ‘fresh eyes’ audit had been conducted in 2017 to 2018. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). We saw a WHO Safe Surgery audit was due to commence March 2017, with an estimated finish date of December 2017. However, the July 2018 update detailed that this was still ongoing. Following our inspection,
the trust informed us that the WHO checklist audit was due to be completed December 2018. We could not see that a ‘swab count’ audit had been conducted in 2017 to 2018; but did see that a ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. The service reported that it did not undertake pain audits.

We saw evidence of several action plans and actions logs within the service. For example, an infection, prevention and control action plan, a sepsis position paper 2018 and associated actions, and a still birth group action plan. However, at our last inspection of the service in May 2017, we found no recommendation of changes to practice in perinatal mortality and morbidity meetings minutes and actions plans were not completed. Following our recent inspection (as described in the Safe, incident section), we could not be assured that these action plans were completed, or recommended changes to practice acted on.

The service had successfully engaged with staff and encouraged more substantive staff to join NHS Professionals (NHSP), and had begun offering unfilled shifts as overtime to staff. Agency staff were now used as a last resort. The service had seen a significant increase in the proportion of bank (NHSP) staff used to fill unfilled shifts, and a decrease in the use of agency staff.

Outcomes from patient engagement activities had been used to inform some improvements within the service. For example, following FFT feedback, the service had introduced ‘welcome to the ward’ leaflets for each inpatient area. In response to concerns about discharge delays on FFT comments, the service had introduced a New-born and Infant Physical Examination (NIPE) clinic, supported by a ward clerk. The service had also developed a dedicated area to function as a discharge lounge, this became fully operational in July 2018.

The service had recently introduced a self-medication service; and provided self-medication lockers so women could self-medicate. The patient-led self-medication service was implemented in November 2017 on Gate 18, the antenatal and postnatal ward, and on the elective caesarean section recovery ward at Pinderfields Hospital; using the trust approved standard operating procedure for consent and risk assessment. We saw evidence that women who had utilised the service provided positive feedback. Senior staff also informed us that the project had improved appropriate and timely administration of medication. In addition, it had also reduced discharge waiting times for take home medications, as these were dispensed as in-patient medication for continued use at home.

The service had commissioned an external company to undertake a thematic review of key sources of maternity feedback in late 2017. An internal co-design workshop was held to identify priorities for improvement in the areas of antenatal, labour and birth, postnatal wards and postnatal community. Five different questions relating to these priorities had been added as a monthly local survey on each of the Maternity FFT cards, at the four points of the maternity pathway.

In addition, senior staff also told us that findings from an MVP ‘always event’ and a ‘15 steps’ workshop in September 2018 would be used to refresh the maternity services improvement plan.

However, whilst we recognised significant work undertaken by the service to collate and map patient feedback, and upcoming work to engage with service users, we were concerned that patient experience action plans in place at the time of inspection were not sufficiently robust, and the service had not acted in a timely way to address identified concerns (for example, in relation to the quality of postnatal (hospital) care).

Since our last inspection, the service had implemented an MBRRACE Perinatal Confidential Enquiry action plan, MBRRACE Saving Lives, Improving Mothers’ Care action plan, and an Each Baby Counts action plan. We also found that the trust were now fully compliant with the Saving Babies Lives Stillbirth Bundle.
We saw that rapid improvement workshops were planned to review delays in induction of labour, and a clinic summit had been organised to evaluate access and flow in the antenatal service. There were task and finish groups for delayed induction of labour and triage, and for antenatal clinic services. However, we were not always assured work was being delivered at a sufficient pace.

The service had introduced new infection prevention control procedures for caesarean sections, following NICE sepsis guidelines (2016). An audit conducted in June 2018 showed the incidence of deep surgical site infection had been reduced from 40% to 5%. A re-audit was planned for November 2018. The service had developed a research collaboration with plastic surgery services at the trust, and the university of Sheffield to take the work forward.

Following literature review and paediatric approval, the service had reformulated the Group B-Strep guideline. The changes meant that women who require GBS prophylaxis in labour were now able to birth in the alongside midwifery led unit. This extended birth place choice to these women.

We saw that ward midwives in inpatient areas used PURPOSE-T, a tool used for risk assessment of pressure ulcers. Midwives reported they had received training to use the tool. This was identified as an area of good practice.

The multidisciplinary labour ward team had won the trust’s clinical team of the year for 2018. The award recognised strong leadership and committed team members who have consistently provided high standards of care and patient safety.
Facts and data about this service

Total number of first and follow up appointments compared to England

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from July 2017 to June 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>428,260</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>186,826</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>172,077</td>
</tr>
<tr>
<td>The Mid Yorkshire Hospitals NHS Trust</td>
<td>1,091</td>
</tr>
<tr>
<td>This Trust</td>
<td>788,254</td>
</tr>
<tr>
<td>England</td>
<td>106,661,135</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at The Mid Yorkshire Hospitals NHS Trust from July 2017 to June 2018 by site and type of appointment.

(IsSource: Hospital Episode Statistics)

Is the service safe?

**Mandatory training**

Most staff had completed their mandatory training. Training figures supplied by the trust were trust wide and were not broken down by site. Outpatients had an overall compliance of 97% for core subject training, with a trust target of 95%. For role specific subjects, the trust target was 85%, outpatients achieved a compliance rate of 80% overall.

Staff we spoke with told us that they had no problems accessing training.

We saw information about staff mandatory training completion displayed on a staff notice board in main outpatients, this alerted staff to the courses they needed to complete.

The training data shows compliance for all staff in outpatients, apart from medical staff. Data for medical staff would be captured under the relevant speciality.

**Mandatory training completion rates**

The trust set a target of 85% or 95% for completion of mandatory training, depending on the module.

**Trust level**

A breakdown of compliance for mandatory training courses from up to the end of June 2018 at trust level for all staff in outpatients is shown below:
## Core MAST Compliance (target 95%)

<table>
<thead>
<tr>
<th>CORE SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Diversity Awareness - Once in Employment</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Infection Control - Every 2 Years</td>
<td>29</td>
<td>289</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 1 Theory - Every Three Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 1 - Every 3 years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Fire Safety - 1 Year</td>
<td>22</td>
<td>296</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Health and Safety Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>30</td>
<td>288</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>TOTAL</td>
<td>93</td>
<td>2769</td>
<td>2862</td>
<td>97%</td>
</tr>
</tbody>
</table>

## Role Specific MAST Compliance (target 85%)

<table>
<thead>
<tr>
<th>ROLE SPECIFIC SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Conflict Resolution - Once in Employment</td>
<td>16</td>
<td>110</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Health and Safety Level 2 - Every 2 Years</td>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 2 practical - Every Three Years</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Medicines Management Level 2 - Every Three Years</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Course Description</td>
<td>Completed</td>
<td>Total</td>
<td>Pass Rate</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------</td>
<td>-------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act (including DOLS) Level 2 - Every 3 years</td>
<td>7</td>
<td>10</td>
<td>17</td>
<td>59%</td>
</tr>
<tr>
<td>Mental Capacity Act (including DOLS) Level 3 - Every 3 years</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Patient Safety - Every Two Years</td>
<td>20</td>
<td>122</td>
<td>142</td>
<td>86%</td>
</tr>
<tr>
<td>Resuscitation Training</td>
<td>16</td>
<td>44</td>
<td>60</td>
<td>73%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 3 Years</td>
<td>16</td>
<td>44</td>
<td>60</td>
<td>73%</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>15</td>
<td>45</td>
<td>60</td>
<td>75%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>119</strong></td>
<td><strong>471</strong></td>
<td><strong>590</strong></td>
<td><strong>80%</strong></td>
</tr>
</tbody>
</table>

**Safeguarding**

There were safeguarding policies and procedures in place for staff to follow, which included protocols for suspected female genital mutilation (FGM). FGM is defined by the World Health Organisation as 'procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons'.

Staff we spoke with could tell us the process they would follow to report any safeguarding concerns and make a referral. Staff could access advice and support from the trust safeguarding team.

In the access, booking and choice call centre we saw safeguarding notice boards, which displayed information about who to contact for adult and children safeguarding concerns.

**Safeguarding training completion rates**

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module.
Trust level

A breakdown of compliance for safeguarding training courses April 2017 to March 2018 at trust level for nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>13</td>
<td>20</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Data provided by the trust after our inspection showed a higher compliance rate, however this was not broken down into the different levels of training.

| NHS|MAND|Safeguarding Adults Level 1 - 3 Years| 2  | 316 | 318 | 99% |
| NHS|MAND|Safeguarding Children Level 1 - 3 Years| 2  | 316 | 318 | 99% |

Cleanliness, infection control and hygiene

All areas we visited were visibly clean and tidy. Dirty utility rooms were noted to be clean and free from clutter. We saw ‘I am clean’ stickers on equipment to indicate that cleaning had taken place.

Hand gel was available in all areas we visited and personal protective equipment, such as gloves were available. We saw that staff observed the arms bare below the elbow policy and washed their hands appropriately.

In main outpatients we saw the results of a hand hygiene audit and bare below the elbows audit carried out in June 2018 on display. This showed scores of 98% for hand hygiene and 100% for bare below the elbows. In the eye centre the results of an audit showed overall compliance of 100% with infection prevention and control measures. Audit data provided showed an average infection prevention and control compliance in June 2018 of 98%.

At our last inspection we noted that there were carpets in main outpatients. At this inspection, we noted that there were no carpets in clinical areas.

We observed MRSA swabs done in the pre-operative assessment clinic.
Environment and equipment

The main outpatient’s department was situated just inside the hospital entrance. There was a main waiting area with electronic check in desks and then further waiting areas in each individual outpatient area. The main outpatient’s department was split into two halves, each had 10 consulting rooms and 10 examination rooms.

The eye clinic and diabetes outpatients were situated in their own buildings within the hospital grounds.

The phlebotomy service was located next to the main outpatient department and had limited space, with no storage space.

Resuscitation equipment was available in every area. The phlebotomy service did not have their own resuscitation trolley but used the trolley from the outpatient’s department which was situated next door. Daily checks were completed and we saw checklists to confirm these had been carried out for July 2018, up to the date of our inspection. In the eye clinic we saw indicated on the checklist the days the clinic was closed and the trolley had therefore not been checked. However, in the diabetic clinic and in main outpatients when the checks had not been completed they had not indicated that this was when the clinic was closed.

We saw that equipment had been electronically tested. Most of equipment we saw was up to date with testing. However, we saw two pieces of equipment in main outpatients that said it was due for a service in November 2017. When we raised this with the manager he told us that the equipment had recently been serviced.

There were systems in place for the correct segregation and disposal of waste, including sharp items.

Assessing and responding to patient risk

At our last inspection, there was a backlog of patients waiting. Some of the waiting lists had been clinically validated but others hadn’t been. At this inspection, staff we spoke with told us that waiting lists had been reduced and that they now had administrative and clinical validation. There was a validation team, which employed 15 validators and was in the process of appointing eight more. Each validator was responsible for a different speciality. An outpatient follow up procedure was used to minimise the clinical risk of patients who were waiting for follow up appointments. Within one month of being overdue, a follow up waiting list report was produced which was reviewed by a patient access team leader, who did an administrative validation. Any possible capacity would be identified and instructions given to booking clerks. Within two months of becoming overdue where no capacity was identified, the list of patients, by consultant, was presented to the weekly speciality control tower, who either identified where capacity could be made available or identified the patient for clinical validation by the consultant. Those plans were reviewed at the following weeks control tower meeting to ensure they had been completed. At three months of becoming overdue, the volume of patient’s overdue by three months or more was escalated to the weekly patient access control tower and patient service managers had to work with their clinical teams to put action plans in place to reduce the volume to zero. Any specialities that were off plan to deliver reduction were escalated to the Executive Access, Booking and Choice Steering Group.

However, when we asked the trust to provide evidence that all patients in the backlog had been clinically validated, they could not provide this evidence. They told us it was not possible to provide this evidence as the list changed daily, with patients removed or added to the list. It was identified on the patient administration system that seven percent of the existing backlog had been through a full administrative and clinical validation process. Thirty nine percent of patients had been added...
to the backlog in the last four weeks and the remaining patients were part way through the process.

In ophthalmology, at our last inspection there were backlogs in new and follow up appointments. Since then, there had been an independent external review and staff had worked to an ophthalmology improvement plan. In a newsletter to staff we saw that the backlog of follow up appointments had been reduced and there were no new patients waiting since February 2017 and no new glaucoma patients waiting since August 2017. The longest backlog patient for ophthalmology was from May 2017.

Staff could tell us the process they would follow for any deteriorating patient, which included contacting the hospital crash team.

Staff told us they would contact the mental health team for advice and support if they had any concerns about a patient’s mental health.

We observed staff following a pre-operative pathway in the nurse led pre-operative assessment clinic. Bloods, electrocardiogram (ECG) and MRSA swabs were done which would identify any possible risks for the patient having surgery.

**Nurse staffing**

The trust has reported their staffing numbers for outpatients below for the period from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse staffing</td>
<td>16</td>
<td>19</td>
<td>85%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

In main outpatients there was one whole time equivalent band five vacancy, which had gone through to recruitment.

Staffing was flexed depending on the clinics that were booked. One registered nurse covered each area of outpatients supported by health care assistants.

Staff we spoke with told us they would cover cross site if needed.

Staffing was historically based on a Monday to Friday service. However, with the introduction of Saturday clinics in some specialities there was a need to increase the number of staff in outpatients.

At our last inspection, there was no matron in post. This position had been recruited to and the new matron had been in post since September 2017. When we spoke with the matron he told us that there was a workforce review in progress, which would be used to write a business case for increased staffing.

The access, booking and choice call centre were in the process of recruiting extra staff at the time of our inspection.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 13.6% for nursing staff in outpatients. This is worse than the trust target of 9%. At Pinderfields Hospital there was one band five vacancy, which had gone through to recruitment.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates
From April 2017 to March 2018, the trust reported a turnover rate of 18.5% for nursing staff in outpatients. This is worse than the trust target of 12%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From March 2017 to February 2018, the trust reported a sickness rate of 13.6% for nursing staff in outpatients. This is worse than the trust target of 4.8%. Service leads told us that staff sickness was closely monitored.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
The manager for outpatients told us that they did not regularly use agency staff. Their own staff would work extra shifts as overtime if needed.
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Planned audiology staffing levels were 24.77 whole time equivalent (WTE) trust wide. Actual staffing levels were 23.46 WTE.

Planned phlebotomy staffing levels were 40.67 WTE trust wide. Actual staffing levels were 38.41 WTE.

Planned staffing levels of qualified physiotherapy staff were 58.95 WTE trust wide. Actual staffing levels were 52.65 WTE.

Planned staffing levels of unqualified physiotherapy staff were 7.20 WTE trust wide. Actual staffing levels were 7.20 WTE.

Medical staffing
There were no medical staff specifically for the outpatient’s service. The medical staff that held clinics were accountable to the specific divisions they worked for.

The individual specialities managed and arranged cover for their clinics.

Records
The outpatient department used a combination of written and electronic records. The paper records only contained an outcome form and patient labels. Previous history was available on the electronic record.

The department used a ‘paper light’ system, which meant that clinicians wrote up their notes following the consultation and these were then taken and scanned on to the electronic patient record.

Staff we spoke with us told us they had no problems accessing patient’s medical records for the clinic.

Staff we spoke with were not aware of any system in place on the electronic record to identify those patients with pre-existing conditions, such as people living with learning disabilities or dementia.
Medicines

Medicines were stored in locked cupboards. All medicines we checked were found to be in date. Regular stock checks were made. However, we noted that in main outpatients the stock should have been checked monthly but there had not been any checks done in January 2018 or April 2018.

Fridge temperatures were monitored centrally and pharmacy informed staff if the temperature fell out of the required range.

In the diabetic clinic, the fridge temperature was not monitored centrally. We saw completed checklists to indicate that regular checks of the temperature had been done.

Prescription pads were kept securely. However, we saw inconsistent recording of when prescription pads had been removed and placed back in to the secure storage.

Incidents

The trust used an electronic incident reporting system. Staff who we spoke with were aware how to report incidents.

Learning from incidents was shared in a monthly newsletter produced by the matron. Staff could tell us about learning from incidents. For example, in the diabetic/endocrinology clinic a file had been started to keep request forms in so that staff could contact patients when they had the correct specimen bottle in the department.

Staff we spoke with understood the principles of the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Following a review of reported incidents between April 2017 and March 2018, we found five serious incidents reported for the ophthalmology service where deterioration in vision may have been due to a delay in appointments. The reports showed a thorough investigation and immediate actions taken, including a review of the glaucoma follow up backlog to ensure those patients at greatest risk were prioritised for urgent review and the creation of additional clinics. An independent review of the service was requested. We saw that duty of candour had been adhered to and the patient’s kept fully informed.
Safety thermometer

The safety thermometer was not used in outpatients. However, outpatients did record and display hand hygiene and bare below the elbow audit results.

They also monitored the number of falls that had occurred in the department.

Is the service effective?

Evidence-based care and treatment

Staff had access to up to date policies and guidelines on the trust intranet. Patient’s care and treatment was planned and delivered in line with national guidance, including the National Institute for Health and Care Excellence (NICE).

A NICE tracker ensured that new guidance and alerts had timeframes and a reporting framework for implementation of the guidance.

Audits were done to ensure practice guidelines followed national guidance. Audits were often undertaken within the specialities.

Staff we spoke with told us that endocrine testing protocols had recently been rewritten and the current evidence available had been reviewed to assist in the development of the protocols.

Nutrition and hydration

Vending machines were available in the main outpatients waiting area and in the eye centre waiting area. Water fountains were available in the smaller waiting areas in the main outpatient department.

The diabetic centre did not have a vending machine or a water cooler but there was a jug of water available for patients.

Patient’s that we spoke with told us that staff did not offer them any food if there were delays with transport, but they knew where they could get food from.

Pain relief

Pain relief was not routinely administered in the outpatient’s department and pain management tools were not used.

Patient outcomes

The outpatients service did not routinely monitor patient outcomes. This was managed by the individual specialities.

Follow-up to new rate

From February 2017 to January 2018,

- The follow-up to new rate for Pinderfields Hospital was lower than the England average.
Follow-up to new rate, The Mid Yorkshire Hospitals NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff

Staff we spoke with told us that they had regular appraisals. These were an opportunity to discuss further development.

Appraisal rates

From April 2017 to March 2018, 78% of staff within the outpatient’s department at the trust received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals who required an appraisal</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met 85% target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>71</td>
<td>56</td>
<td>78.9%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>282</td>
<td>220</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>19</td>
<td>12</td>
<td>63.2%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>376</strong></td>
<td><strong>292</strong></td>
<td><strong>77.7%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The appraisal rates provided by the trust were not site specific or broken down. Although the completion rate for qualified nursing staff was 63.2%, this was only seven staff members that had not had an appraisal.

In the eye clinic we saw a staff newsletter that said that appraisal rates were 82% for staff in the eye clinic. In main outpatient's appraisal rates were 100%.
Following our inspection, we were provided with updated appraisal figures, however these were not broken down by staff group. These showed a compliance rate of 95% for outpatients overall.

<table>
<thead>
<tr>
<th>Appraisal Compliance (target 85%)</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>377 LOCAL Appraisal Core</td>
<td>14</td>
<td>282</td>
<td>296</td>
<td>95</td>
</tr>
</tbody>
</table>

Phlebotomy staff had a competency document for new starters. Band 3 staff had competency documents to complete for extended roles, such as venepuncture and electrocardiographs (ECG). There were several nurse specialists that ran nurse led clinics. For example, endocrinology, ophthalmology, respiratory, vascular and neuro-vascular. In house training and external training was offered for band six nurses to develop nurse led clinics. Staff we spoke with that had not worked in the service long told us that there was a good preceptorship package. We spoke to a new staff nurse in the eye clinic who told us that they had a progression plan and were undergoing some additional management training. Specialist endocrine nurses received training from the clinical physics department, to use radioactive iodine.

**Multidisciplinary working**

The outpatient departments had a range of staff working together as a multidisciplinary team. Various specialities held multidisciplinary team meetings. In the diabetes and endocrine clinic, podiatrists and dieticians worked alongside consultants and nurse specialists.

**Seven-day services**

Most outpatient clinics were held Monday to Friday. However, some specialities were starting to hold clinics over six days of the week. Additional clinics were held on evenings and weekends to meet demand. The phlebotomy service was open Monday to Friday 8am until 4.30pm.

**Health promotion**

There were several health promotion leaflets located throughout the departments. In the diabetic centre clinic, we saw information displays related to antibiotics and their use. We heard a nurse advising a patient on alcohol abstention prior to surgery.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their responsibilities when obtaining consent from patients. Staff we spoke with told us that if they had concerns that a patient was lacking mental capacity and had attended the department unaccompanied, they would contact the mental health team for advice and support. Staff had access to a consent policy and mental capacity policy.
Mental Capacity Act and Deprivation of Liberty training completion
Staff compliance with mental capacity act training at the end of June 2018 is shown below, this is not site specific:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>316</td>
<td>318</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Is the service caring?

Compassionate care

We observed staff to be kind, caring and compassionate. We heard staff introducing themselves to the patients.

All consultations and examinations took place in closed rooms, ensuring privacy and dignity was maintained. However, there were some issues with privacy at the reception desk as the area was open.

Chaperones were available and signs were displayed in clinics informing patients that they could request a chaperone if required.

Patients we spoke with told us that staff were friendly, polite and helpful.

Friends and family test (FFT) results for May 2018 showed that 97% of patients would recommend the outpatient department to their friends and family.

Emotional support

Clinical nurse specialists were available in several clinics, they could provide additional support to patients.

Some specialities had psychologists who provided support to patients with life changing diagnoses.

Understanding and involvement of patients and those close to them

Patient’s relatives could accompany them for their consultation.

Patients we spoke with told us they felt that they were fully informed and staff had explained things to them. We observed patients being given the opportunity to ask questions.

Patients we spoke with told us that consideration was given as to which hospital site they were seen at, if this was possible. We observed a discussion with a patient which included the hospital choice and saw that the issues around the choice were documented.
Is the service responsive?

Service delivery to meet the needs of local people

Additional clinics were offered on an evening and at weekends to meet the demands of the service.

Appointments for most specialities were available across the three sites but some of the services were only available at Pinderfields hospital.

Patients could access shuttle buses between the three sites, these enabled patients travelling from other areas to attend the hospital.

Transport was provided for those patients that needed it. Patients that we spoke with said they had no problems with the transport and it was always booked when it was needed.

Signposting to the departments was generally clear, although signposting to the diabetic centre was not as clear. In the diabetic centre we saw a ‘you told us, we did’ display, which showed that patients had told them that they wanted location signs improving. The service had made a request for more signs.

Outside the main outpatient department volunteers were available to help patients use the check in screens and help them find the right department.

The eye clinic ran an emergency helpline. The emergency department, general practitioners and opticians used this to refer patients in an emergency, this ensured patients were seen and treated urgently.

In those areas where children could be seen, such as the eye clinic, there was a separate children’s waiting area with age appropriate toys.

Some specialities had started e-consultations with general practitioners. This allowed them to discuss a patient and potentially avoid an unnecessary referral.

Meeting people’s individual needs

Clinics we visited had a range of patient information leaflets, some of these were available in different languages.

Staff told us they could access interpreters and these would be booked to attend the appointment with the patient. The department also maintained a list of staff in the trust who were bi-lingual or multi-lingual.

A trust dementia nurse and learning disability nurse were available to provide advice and support to staff. If the department knew that there was a patient living with learning disabilities or dementia due to come to clinic they put a plan in place. The learning disabilities team would contact the patient/carer and the outpatient’s department to form a plan for the visit.

Staff had received dementia training as part of their mandatory training.

VIP passports were used, which gave specific information about an individual’s needs.

Bariatric beds, chairs and wheelchairs were available. The wheelchair was fitted with a transmitter to enable it to be easily located by staff when needed.

Throughout the clinics we saw a leaflet for patients to complete and send to the trust if they had any communication needs. This ensured that any communication needs were highlighted and flagged up on the system. Staff we spoke with told us they knew of patients that required large
print letters and they had seen patients attend with these. This ensured that the service was meeting the Accessible Information Standard (2017). The ‘Accessible Information Standard’ – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The access, booking and choice team had close links with the prison service, which streamlined the referral. In some cases, it had been arranged for the consultants to go in to the prison to carry out the appointment.

Staff worked closely with the mental health team and knew how to refer to them. They would plan for patients with mental health needs. For example, staff were aware that one patient would throw things and so they prepared the room before the clinic by removing items from the consulting room.

**Access and flow**

At our previous inspection, there were concerns with waiting backlogs and referral to treatment times. At this inspection, we found that although there was still a backlog of patients waiting for appointments this had improved and referral to treatment times had also improved, despite an increasing number of referrals.

At our last inspection, the backlog of patients waiting was 19,647, this had reduced to 17,516 in June 2018. There had been a reduction in the number of patient’s waiting more than 35 weeks from 449 in June 2017 to 193 in June 2018. There were no patients waiting over 52 weeks. Following our inspection, we requested the figures for the current backlog. By week ending 22 July 2018, the backlog was 18,374.

Some specialities, such as ophthalmology and trauma and orthopaedics, which had the biggest backlog, had decreased their backlog whilst for others, such as gastroenterology, neurology and rheumatology, it had increased. It was not clear what the reason for the increases were in some services, there was no evidence that increased referrals to the service had an impact on the backlog. Ophthalmology still had the highest backlog but this had reduced from 6942 at our last inspection to 5407 in April 2018. Data received following the inspection showed that this had reduced further still to 5272 by the 25 July 2018.

We saw a waiting list initiative spreadsheet, which had been produced so that extra clinics could be held. This indicated the speciality, how many consultants there would be, rooms needed and the proposed date and time of the clinic. This spreadsheet was then checked by the matron and managers who indicated whether a room and a nurse could be provided for the clinic to take place.

The outpatient efficiency dashboard showed a target of 95% for clinic slot utilisation, between January and March 2018 clinic slot utilisation was at 85.5%.

The service had undertaken several initiatives to try to balance capacity and demand, including increasing internal capacity through some evening and weekend clinics, carrying out an in-depth review of ophthalmology services and increasing the use of alternative providers, for example dermatology patients may be triaged as being suitable to be seen by an independent provider.

The trust had worked closely with the local clinical commissioning group (CCG) to reduce waiting times and improve performance against cancer targets. Summit meetings were held which brought together secondary and primary care along with the CCG to look at the whole pathway.

We asked for evidence of clinical and recovery plans for high risk specialities. We were provided with an ophthalmology service improvement programme and an endoscopy surveillance trajectory briefing. These showed that endoscopy services had planned to clear their backlog by June 2018,
but this had not been achieved and at the 22 June 2018 there were still 162 patients waiting. It was not clear from the ophthalmology improvement programme what the trajectory was for clearing the backlog.

At our last inspection, no specialties were above the England average for non-admitted referral to treatment times (RTT) or incomplete pathways RTT and there had been a downward trend in performance. At this inspection, although the trust performance had been worse than the England average overall, figures showed an increasing performance and three specialties were above the England average for non-admitted pathways and five specialties were above the England average for incomplete pathways.

In May 2017, the trust ranked 182 out of 189 nationally for their 18-week performance, in May 2018 this had improved to 130 out of 185.

Data provided by the trust showed that the number of non-admitted breaches, waiting more than 18 weeks had decreased from 3998 in June 2017 to 2459 in June 2018.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From May 2017 to March 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways had been worse than the England overall performance. The latest figures for March 2018 showed 83.9% of this group of patients were treated within 18 weeks versus the England average of 80.8% showing an increase in performance against the England average.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways**

![Graph](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Three specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>91.0%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87.7%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>86.0%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>
15 specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>91.3%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>89.1%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Other</td>
<td>88.5%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>88.0%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>87.0%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>85.4%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>84.5%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.3%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>83.3%</td>
<td>89.6%</td>
</tr>
<tr>
<td>ENT</td>
<td>76.3%</td>
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</tr>
<tr>
<td>Oral surgery</td>
<td>70.6%</td>
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</tr>
<tr>
<td>Gastroenterology</td>
<td>67.3%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>62.4%</td>
<td>88.3%</td>
</tr>
<tr>
<td>General medicine</td>
<td>61.9%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>61.0%</td>
<td>89.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for incomplete pathways had been worse than the England overall performance, and had not met the 92% target.

The trust performance has shown a steady increase since April 2017 but as of February 2018 remains below the England average.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, The Mid Yorkshire Hospitals NHS Trust.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Five specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>97.3%</td>
<td>96.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>96.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>92.2%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>89.5%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>84.6%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

12 specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks)

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>88.6%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Other</td>
<td>87.7%</td>
<td>90.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>86.8%</td>
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</tr>
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<td>91.5%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>82.8%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>81.6%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>77.1%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>73.5%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>71.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>67.9%</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust had performed better than the operational standard for cancer waiting times. Although there had been a slight decline in performance for people waiting less than 62 days for urgent GP referral and they had not met the standard for quarter four of 2017/18, they were still in line with the England average. This was an improvement since the last inspection when the trust had performed worse than the operational standard.

When we spoke with staff about this they told us that they had seen an increased number of referrals linked to public health campaigns. They had recently recruited more staff and were holding weekly breach meetings, looking at those patients who had been waiting over 50 days to try and move forward. Extra clinics were held and root cause analysis done on every breach.
Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, The Mid Yorkshire Hospitals NHS Trust

Patients we spoke with told us they did not have long waits in the departments, but if there were any waiting times then the staff let them know. The acute clinic in the eye centre had developed a patient information leaflet to explain why they may have a long wait in the department. We did not observe any long waiting times whilst we were on inspection.

Did not attend rate

From February 2017 to January 2018,

- The ‘did not attend’ rate for Pinderfields Hospital was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, The Mid Yorkshire Hospitals NHS Trust

Patient feedback had included that they would like an appointment reminder. A texting pilot had been rolled out, where texts were sent to patients to remind them of their appointments.

A pilot was underway in plastic surgery for patient initiated follow up, where an appointment date and time would not be sent but a letter sent asking the patient to call to make an appointment that was convenient for them.

One patient told us they had missed an appointment because they had not received a letter but they rang the service and were able to book another appointment within a short space of time. However, we also observed a patient arrive in the fracture clinic who was told that their
appointment had been rearranged, but the patient had not been made aware of this. No offer was made to the patient to see them that day if possible, but staff apologised to the patient, checked their contact details and provided a copy of the new letter.

The access, booking and choice call centre had a target of answering 95% of calls within three minutes. Between June 2017 and April 2018, 90.8% of calls were answered within three minutes. During our inspection we saw that they were meeting the 95% target and the average time taken to answer a call was 13 seconds.

Learning from complaints and concerns

We saw information displayed informing patients how to make a complaint. Leaflets were available for patients which told them how to make a comment, complaint or express their appreciation. The leaflet contained contact details for the complainant to use to submit a complaint, an explanation of what would happen next, and of what to do if the patient remained dissatisfied following the investigation of their complaint.

Summary of complaints

From April 2017 to March 2018 there were 298 complaints about outpatients trustwide. The trust took an average of 29 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 30 days.

Complaints in relation to patient care accounted for 47% of all complaints received and were the largest theme in outpatients.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Although these complaints appear to relate to outpatients, most of them were dealt with by the specialities and were not specific to the outpatient department.

The last formal complaint made specifically about the outpatient department was in March 2017.

Staff we spoke with told us that most complaints were informal and were resolved at department level.

Number of compliments made to the trust

From April 2017 to March 2018 there were 115 compliments within outpatients.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The outpatient’s department was part of the division of surgery, access, booking and choice. Access, booking and choice had a deputy director of operations, a patient services manager and a group manager.

Since our last inspection there had been a change in the leadership. A new lead had been appointed for the access, booking and choice directorate and a new outpatient matron had been appointed. The outpatient matron had been in post since September 2017. Prior to this, staff told us they were without a matron for around 18 months.
Staff we spoke with were positive about their leaders, from the local leadership to the wider leadership of the trust. Staff told us that leaders were visible and supportive and they felt that the chief executive and director of nursing & quality listened to staff.

Senior managers and leaders we spoke with understood the challenges in their service and were proactively trying to manage these.

**Vision and strategy**

In areas we visited we saw the trust values displayed. Staff we spoke with were aware of these values.

An outpatient mission statement was visible in the areas we visited.

The outpatient service had developed its strategy in line with the trust strategy.

**Culture**

All staff we spoke with liked working for the trust and enjoyed their jobs. Morale was good.

Staff told us their focus was on the patients and that they worked well as a team to achieve the best outcomes.

Staff spoke of good communication at all levels and felt they knew what was expected of them.

**Governance**

The division of surgery, access, booking and choice had a clinical governance manager.

There were governance structures in place which ensured that information was fed from operational level up to board level. The access, booking and choice directorate held governance meetings, these reported to the divisional governance meetings, which in turn reported to the quality committee and this reported to the board of directors. Any serious issues could be escalated through these meetings up to board level.

Governance meetings looked at incident reporting and any trends, new guidance and alerts and reviewed the risk register.

**Management of risk, issues and performance**

Risk registers were reviewed monthly in governance meetings. Risks of 12 or above were referred to the divisional governance meetings. Divisional risk registers were then reviewed at the quality committee meetings.

A risk register was in place for the access, booking and choice directorate.

An outpatient efficiency dashboard had been developed to help specialities view and manage their performance against four key outpatient improvement schemes and associated key performance indicators. This gave information on hospital generated outpatient appointment cancellations under six weeks, did not attend (DNA) rates by speciality, consecutive DNA’s and clinic slot utilisation by speciality.

Joint planned care meetings were held fortnightly with commissioners to monitor performance.
Information management

The access, booking and choice team had access to an electronic performance information board with live information displayed about calls coming in and the time taken to answer.

Electronic requesting software was used for electronic requests for follow up appointments.

Standard operating procedures and process flows were available to support outpatients staff.

The service used the data it had in weekly and monthly performance reports and dashboards, which helped determine priorities.

Engagement

Staff we spoke with told us they could access a lot of information online. Staff said they could email the chief executive and he would respond to concerns.

Some team meetings took place although these were not always regular due to workload.

However, the matron produced a monthly newsletter which staff found very useful, this included updates on relevant topics and any lessons learned from incidents or complaints.

The ophthalmology service also produced its own newsletter, which provided staff with relevant updates.

A stakeholder forum had been involved in the redesign of clinic letters.

There was a patient representative for the division on the trust patient experience group.

We saw ‘you told us, we did’ information displayed in the clinics. For example, in the eye centre patients had said that the time spent in clinic was too long, the service had responded by developing a patient information leaflet to explain the time that would be spent in clinic.

Learning, continuous improvement and innovation

The fracture clinic had won a clinical team of the year award in 2017.

The access, booking and choice team had won an award for outstanding non-clinical initiative for their links with the prison and maintaining confidentiality.
# Acute services

## Dewsbury and District Hospital

### Evidence appendix

Halifax Road  
Dewsbury  
West Yorkshire  
WF13 4HS  
Tel: 08448118110  
http://www.midyorks.nhs.uk  

Date of inspection visit: 3 Jul to 2 Aug 2018  
Date of publication: 7 December 2018

### Urgent and emergency care

#### Facts and data about this service

Urgent and emergency care services are provided at all three hospital sites:

- Dewsbury and District Hospital emergency department (ED)
- Pinderfields Hospital ED
- Pontefract Hospital urgent treatment centre (UTC)

Following a reconfiguration of acute hospital services at the trust, which was completed in September 2017, emergency and complex care is now centralised at Pinderfields Hospital. Dewsbury and District Hospital has a focus on elective and non-complex care. As a result, the ED has a protocol in place, in agreement with Yorkshire Ambulance Service (YAS), regarding the patients who can be admitted by ambulance, and no pre-alerts for unwell patients to be seen in the resuscitation room are accepted at Dewsbury. Acutely unwell patients are taken to Pinderfields ED by ambulance, but may still self-present to Dewsbury ED. The department at Dewsbury is open 24 hours a day, seven days a week. It has a separate children’s ED which is part of the division of medicine; the nursing staff are managed by the division of families and clinical support services. The children’s ED is also open 24 hours a day, seven days a week. Patients requiring admission from the ED are transferred to Pinderfields Hospital, unless they fit the criteria for admission to the frailty unit, clinical decisions unit or ambulatory care unit at Dewsbury. There is a walk-in centre located within the department which is run by a local community services provider.

#### Activity and patient throughput

**Total number of urgent and emergency care attendances at The Mid Yorkshire Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017**
From April 2016 to March 2017 there were 236,645 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

![Bar chart showing percentage of A&E attendances resulting in admission]

The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2016/17 compared to 2015/16. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, January to December 2017

[Diagram showing urgent and emergency care attendances by disposal method]
Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training and 95% for role-specific mandatory training.

Trust level

At our last inspection in 2017 we found that mandatory training levels were not meeting the trust standards. This was also a finding from our inspection in 2015. At this inspection the staff we spoke to told us they had completed their mandatory training, or had plans in place to do so. The data we reviewed showed in urgent and emergency care across the three sites, the trust target of 95% was met for four of the nine mandatory training modules. The remaining five were below trust standard and ranged from fire safety at 77% to safeguarding children at 94%. The overall trust compliance rate for mandatory training was 90%.

The trust target of 85% was met for three of the 16 role specific mandatory training modules. Nine modules had a compliance rate of 75-85%. The remaining four modules were below 75%, these were: safeguarding children level 2 at 68%, safeguarding children level 3 at 73%, annual resuscitation training at 69% and Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) training at 52%. The trust was unable to provide site or role-specific data. The overall trust compliance rate for role-specific mandatory training was 78%.

We spoke to the clinical educator for the department who had been in post for seven months, and who was visibly keen to improve access to training and training standards. An education strategy was in place and staff training compliance was closely monitored. Staff could access training online from work and home computers, and alerts were generated automatically to inform them when training was due. The clinical educator followed up these alerts to encourage staff to remain compliant. A separate record of mandatory training compliance was kept in the children’s ED. Staff
told us they were happy with their ability to access mandatory training but sometimes they had to wait for places on face-to-face training courses to become available. Band 5 nursing staff were not able to access Advanced Life Support (ALS) or Trauma Nursing Core Course (TNCC) training due to financial constraints, but the department undertook local trauma and resuscitation training courses to try and mitigate this.

**Safeguarding**

Safeguarding training for adults and children (level 1) is part of the trust’s mandatory training programme and eligible staff must complete it every three years. The trust set a target of 95% for completion of safeguarding training. There were 276 urgent and emergency care staff eligible for safeguarding adults level 1 training, with a compliance rate of 92%. There were 276 urgent and emergency care staff eligible for safeguarding children level 1 training, with a compliance rate of 94%. The information provided to us was at trust level and was not broken down into staff groups or hospital site.

Safeguarding training for adults (level 2) and children (levels 2 and 3) is part of the trust’s role specific mandatory training and eligible staff must complete it every three years. The trust set a target of 85% for completion of role specific safeguarding training. There were 231 urgent and emergency care staff eligible for safeguarding adults level 2 training, with a compliance rate of 74%. There were 74 urgent and emergency staff care eligible for safeguarding children level 2 training, with a compliance rate of 68%. There were 157 staff eligible for safeguarding children level 3 training, with a compliance rate of 73%.

At this inspection the service had systems in place to identify and manage children and adults at risk of abuse, including domestic violence. The safeguarding policy was available to staff on the intranet. Staff we spoke to, in both the adult and children’s EDs, told us they had completed safeguarding training as part of their mandatory training, which included specific training about child sex exploitation (CSE), female genital mutilation (FGM) and domestic violence.

Nursing and medical staff told us they knew how to recognise a potential safeguarding concern, and knew how to raise concerns. They could describe the process, give examples from their own practice and demonstrate how to access trust guidelines.

Safeguarding alerts were flagged on children’s records; these would be picked up by reception staff and the appropriate nursing staff alerted. Children’s records were reviewed daily by paediatric liaison nurses to check that information had been completed correctly and shared appropriately, for example with general practitioners (GPs), health visitors and school nurses, and to ensure no incidents had not been overlooked. It was also possible for staff to refer families to the safeguarding team for support, such as for contact with a health visitor. Assessment documentation for both adults and children contained sections for safeguarding information to be completed by staff and the number of previous attendances was recorded. We observed a junior doctor ask a consultant for advice regarding a child under two years of age who attended the department and had three previous admissions in the last year. The doctor explained his concerns regarding safeguarding and the consultant assisted with the completion of a safeguarding assessment. No concerns were identified, but the child was admitted to Pinderfields in line with trust policy.

At our last inspection we said the trust should ensure that families discussed at a MARAC should be flagged on the electronic system. At this inspection we found that flagging still did not routinely occur. Following inspection, the trust has informed us that a system of ‘consensual’ flagging was planned to commence; those involved in a MARAC who gave consent would be flagged on electronic records. This was discussed at the quality committee meeting in June 2018. Staff told us that they identified very few incidents of domestic violence and none had gained patient consent to make a referral, however they were aware of the referral process and were able to
provide patients with a helpline number. One of the healthcare assistants (HCAs) in the adult ED was a link worker for domestic violence.

**Cleanliness, infection control and hygiene**

During inspection we found the department, children’s area, waiting rooms and toilets to be visibly clean and tidy, and saw cleaning in progress at several times during our visit. In the paediatric ED, toys met infection control standards and had been cleaned regularly. The trust had an infection, prevention and control policy, which directed staff to other policies and protocols for guidance about cleaning, decontamination and personal protective clothing. Infection control training is part of the trust’s mandatory training programme, and staff must complete it every two years. In urgent and emergency care across the trust there is a target of 95% compliance, with an actual compliance rate of 87%.

In the resuscitation room we found unused equipment stacked on a windowsill which was dirty and covered in dust. There were boxes of equipment stored under the stacker drawers in the resuscitation room that were also dirty and appeared unused.

We checked ten mattresses in the department and all were clean and intact. We viewed monthly mattress audits completed by the ward manager and were assured that all mattresses were thoroughly checked and those unfit for purpose were documented and removed. ‘I am clean’ stickers were used routinely around the department on reusable equipment, and all those we checked had been dated and signed correctly. All equipment appeared clean and we observed staff disinfecting equipment between patients. Sharps bins were stored at an appropriate height and had not been overfilled. They were signed and dated correctly and apertures were temporarily closed when not in use, in line with national guidance. Disposable curtains were in use around the department and staff completed cleaning checklists in each cubicle.

Personal protective equipment (PPE), including aprons and gloves, was readily available in all areas of the department. There was good access to handwashing facilities and hand sanitising gel. We observed staff using correct hand decontaminating procedures, and they were compliant with the trust’s ‘bare below the elbows’ and uniform policies. Information on audits from June 2018 was displayed in the department; local hand hygiene and bare below the elbows audits had both scored 100%

We spoke to domestic staff who told us that they had a cleaning schedule but no checklists were completed. They did however have a handover book in which they recorded what they had done, so that outstanding tasks could be passed to the oncoming shift. They felt the system worked well and jobs were always completed. They told us that they took pride in their work and enjoyed working in the ED; the environment was friendly and the staff approachable. We saw different coloured mops and cloths used for different areas. Hazardous substances were stored in a locked cupboard, with the key stored securely at the nurses’ station. We checked the sluice room and found it to be clean and well organised, with waste and laundry separated appropriately. Regular flushing, for example of showers, to prevent infections such as legionella, was carried out daily and signed off by the estates department.

The department had cubicles available for patients who required isolation for the prevention and management of actual or potential infection, and there was a separate decontamination room.

**Environment and equipment**

The waiting area for patients registered was located next to reception and was an adequate size with secured seating, however the seats faced away from the reception desk so patients were not directly visible to reception staff. There was a separate entrance for ambulance patients.
The designated mental health assessment room was located on a busy corridor in the majors’ department. It was also used as a private room for families/carers. Staff could see into the room through an observation window if they needed to monitor a patient who posed a risk to themselves or others, but there was a partial blind spot behind the door which was not visible from the outside. Patients used the public toilets opposite the nurses’ station. The room had several ligature points; points to which a cord, rope or other material could be attached for the purpose of hanging or strangulation. This was highlighted at the time of inspection and the trust informed us that they had already escalated the risk and work was ongoing to address the issue as a matter of priority.

The resuscitation room had four treatment bays, one of which had monitoring and treatment equipment in place specifically for children. This bay was checked and maintained by staff from the paediatric ED. We found resuscitation equipment in the bays to be in good order, with evidence of daily checklists being completed, but the checklist files were disorganised and it was difficult to find the relevant information. Resuscitation trolleys were stocked appropriately and all equipment checked in the bays was in date. We checked electrical equipment, including patient monitors, and all portable appliance testing (PAT) labels were up to date. There was a trolley in the resuscitation room which was stocked and labelled for use for patients with sepsis. According to the checklist this should have been checked daily, but the checklist had not been completed. There was age-specific equipment for children stored in separate boxes; these were labelled but were sealed with pieces of tape which were easy to tamper with. The expiry dates had been written on the tape, but some dates had been crossed out and rewritten so we did not have assurance that equipment was in date, complete or that the checking procedure was robust. There were equipment kits in ready prepared boxes, for use during specific emergency procedures, which had been sealed with pieces of tape that were easy to tamper with. Expiry dates had been written on the tape but were difficult to read, and one box was labelled as being out of date. We checked inside the box and there were items of equipment that were significantly out of date. This was escalated to the nurse in charge.

There was a separate children’s emergency department (ED) with a secure entry system, where paediatric patients went directly after registering. The children’s ED consisted of a waiting room, four cubicles, a side room and a high dependency cubicle, for children needing close observation. All equipment checked in here was stored appropriately and was in date. The whole area appeared child friendly; the waiting area had toys, books and a television and the cubicles had pictures on the walls drawn by local schoolchildren. We checked items of electrical equipment in the children’s area and found some portable appliance testing dates were overdue; this was highlighted to the nursing staff. We were informed that the medical physics department was responsible for testing on a rolling programme, which was closely monitored, and there was a 60-day period from the recorded due date in which the items could still be tested. They were aware of testing dates and all items were safe to be used.

We found that all consulting and treatment cubicles in the department were an appropriate size and contained the necessary equipment. The majors’ area was well laid out, with all cubicles visible from the nurses’ station and central area.

We checked the major incident equipment storeroom and found equipment to be labelled, organised and in date. We were told that the emergency preparedness team from Yorkshire Ambulance Service (YAS) had audited the stores two months previously, then changed and updated some of the equipment.

Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored “about the same as other trusts” for all five of the Emergency Department Survey questions relevant to safety.
<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>before being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from April 2017 to March 2018.

In March 2018 the median time to initial assessment was 17 minutes compared to the England average of 9 minutes.

Ambulance – Time to initial assessment from April 2017 to March 2018 at The Mid Yorkshire Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Dewsbury and District Hospital

From May 2017 to April 2018 there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Dewsbury and District Hospital.

In April 2018, 33% of ambulance journeys had turnaround times over 30 minutes.
Ambulance: Number of journeys with turnaround times over 30 minutes - Dewsbury and District Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Dewsbury and District Hospital

(Source: National Ambulance Information Group)

Following the inspection, the trust provided ambulance handover data for all three hospital sites for the period May 2017 to July 2018. This data shows that over this period the percentage of ambulance handovers over 30 minutes ranged from a maximum of 4.3% in December 2017 to a minimum of 0% in May and July 2018. From February 2018 there was a substantial reduction in the percentage of handovers over 30 minutes at Pinderfields Hospital.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From March 2017 to February 2018 the trust reported 139 “black breaches”, with an upward trend over the period.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of black breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>2</td>
</tr>
<tr>
<td>April 2017</td>
<td>5</td>
</tr>
<tr>
<td>May 2017</td>
<td>3</td>
</tr>
<tr>
<td>June 2017</td>
<td>5</td>
</tr>
<tr>
<td>July 2017</td>
<td>8</td>
</tr>
<tr>
<td>August 2017</td>
<td>10</td>
</tr>
<tr>
<td>September 2017</td>
<td>22</td>
</tr>
<tr>
<td>October 2017</td>
<td>17</td>
</tr>
<tr>
<td>November 2017</td>
<td>3</td>
</tr>
<tr>
<td>Month</td>
<td>Number of black breaches</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>December 2017</td>
<td>39</td>
</tr>
<tr>
<td>January 2018</td>
<td>25</td>
</tr>
<tr>
<td>February 2018</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Data provided by the trust following inspection showed that there had been no further black breaches in the trust between February 2018 and June 2018.

Since the completion of the acute hospital reconfiguration (AHR) in September 2017 Pinderfields Hospital has become the main receiving ED for patients who are acutely unwell or have complex needs, meaning fewer patients are now admitted by ambulance to Dewsbury Hospital. We saw two patients arrive by ambulance and both received initial assessment within 15 minutes. We reviewed ten patients records and found that seven received initial assessment within 15 minutes; the median time from arrival to initial assessment was 19 minutes.

At our last inspection we found that recording of national early warning scores (NEWS) was not consistent. The trust used a national early warning score (NEWS) to identify a patient’s condition based on their recorded clinical observations; the NEWS indicates whether a patient is stable, improving or deteriorating and therefore requires escalation to a higher level of care. At this inspection we reviewed 10 sets of adult notes and found that 8 had clinical observations/NEWS recorded.

We were also concerned previously that the triage training process was not robust and varied across the trust, with relatively inexperienced nurses carrying out triage. At this inspection we found that all registered nurses were trained in triage assessment and used a recognised triage tool, including staff in the children’s ED. Nursing staff who had been in post for six months or more and who had completed the triage training, could carry out triage once their competency had been assessed.

An initial streaming process took place when patients registered at reception; on inspection we were concerned that this was done by reception staff who were not clinically trained. This is not in line with national guidance. Patients were streamed using a flowchart into ‘red chairs’ for majors and ‘blue chairs’ for minors, depending on their initial clinical presentation. They were either asked to wait in the waiting room, or directed to follow coloured footsteps on the corridor to the appropriate area; red footsteps led to the nurses’ station and initial assessment area for majors’ patients; blue footsteps led to the minor injuries area where patients were seen and treated. There was also a walk-in centre adjacent to the minor injuries area, which accepted direct referrals from the ED. The seats in the waiting area were positioned to face away from the reception, so if a patient became unwell it may not be immediately noticed, and the waiting room could not be viewed from the main clinical area.

Staff in the department had access to appropriate triage and risk assessment tools to support them to identify and assess patients with suspected mental health conditions. This included an assessment of any immediate risk patients may pose to themselves or others, due to their presenting mental health problems. The risk assessment tool was traffic light rated – red, amber, green - with clear recommended action staff should take depending on the assessment of a patient’s initial mental health assessment and associated risk. Patients who presented with higher risks of harm to themselves or others were observed by emergency department staff or security staff. Patients waiting for an in-patient bed at a mental health facility could remain in the emergency department for up to 24 hours, often observed by security staff. The psychiatric liaison team was available 24 hours a day, seven days a week. The team aimed to respond quickly to referrals made by the emergency department, usually within one hour.
All cubicles were equipped with patient call bells, and each patient we spoke with had access to the call bell. We viewed monthly audits completed by the department matron and it was documented that 100% of patients reviewed had a call bell available.

Patients told us they felt safe in the department. We saw that patients at risk of falls had been assessed and were given a green wristband to help identify them to staff as needing more support with mobility.

A patient safety checklist had been developed for staff to complete at regular intervals, giving details of patient care actions and assessment to be undertaken. We reviewed the checklist audit carried out in June 2018 and, of the ten patients’ notes that were reviewed, 100% had checklists in place. During our inspection we reviewed the notes of seven patients who had prolonged stays in the ED (over four hours) and all had safety checklists completed.

We spoke with the sepsis lead consultant who told us that there had been significant improvements in sepsis care within the trust. Sepsis assessments were completed in order to flag patients at risk, and a pathway was followed to provide a specified bundle of care. The trust had appointed a designated sepsis nurse and there was a children’s sepsis pathway also due to be published. During inspection we observed four patients in the department being treated for sepsis and found that management was inconsistent: one had been managed well with the sepsis pathway followed, one had not been escalated appropriately, one had received the incorrect antibiotic treatment and one had not received the sepsis bundle. A monthly department audit showed that, out of ten patients’ records reviewed, none were eligible for sepsis screening.

We reviewed incident reports involving children at Dewsbury ED, from June 2017 to June 2018. In total there were 15 incidents reported: six involved delays with ambulance transport; four involved issues with nurse staffing levels; one related to a birth on site out of hours; two were due to issues with other services and two were communication/administration errors.

**Nurse staffing**

The trust reported the following qualified nursing staff numbers from April 2017 to March 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse staffing</td>
<td>150</td>
<td>155</td>
<td>87%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 12.8% for nursing staff in urgent and emergency care. This is worse than the trust target of 9%. 
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 10.6% for nursing staff in urgent and emergency care. This is better than the trust target of 12%. 
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**
From March 2017 to February 2018, the trust reported a sickness rate of 5.2% for nursing staff in urgent and emergency care. This is similar to the trust target of 4.8%.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

At our last inspection, we found that nurse staffing in the department did not always meet planned staffing levels. Nursing staff were frequently moved to other areas to cover staffing shortages, thus leaving the ED short-staffed. Bank and agency nurses were used to cover gaps in the rota. At this inspection we were told that nursing staff were often moved to cover vacant shifts at Pinderfields ED. There were concerns that staffing levels in the department became unsafe, particularly if a qualified nurse was then required to leave the department to escort a patient on ambulance transfer, which was a regular occurrence. We were told that shift leads were beginning to document the occasions when nurses had to leave the department to escort patients, and any concerns identified because of this would be recorded.

During the day the nursing and healthcare staff were allocated to work in specific areas for the duration of their shift. The majors’ area was split by cubicle numbers into three specific areas, to provide consistency for staff and patients. There was a nurse working as shift lead who would oversee the department, review patient status and report issues within ED as necessary. Designated nursing staff also worked in the assessment area and the resuscitation room. The minor injuries area was staffed by Emergency Nurse Practitioners (ENPs). There were two registered children’s nurse on duty in the children’s ED apart from between 7am-9.30am when there was one. This does not meet national guidance which says there should be two trained staff at all times. Four incident reports from June 2017 to June 2018 involved unsafe nurse staffing levels in the children’s ED. We were told that nurse staffing had been assessed according to department demand and that this was due to be reassessed.

We reviewed four weeks of nursing rotas to compare the planned and actual registered nurse figures. All day shifts except one were covered with the planned number of registered nurses. There was a late shift running from midday to 12.30am, which had a requirement of one registered nurse per shift; this was covered for all shifts except one. There was a twilight shift in the department running from 2pm to 2.30am, which had a requirement of one registered nurse per shift; this was covered on all but four occasions. Overnight, there were 5 planned registered nurses in the department; three of the shifts we looked at had four nurses and the rest were fully staffed.

We were told on inspection that the department relied on agency nurses to fill gaps in the rota. Data supplied to us by the trust showed that, in the three-month period from April to June 2018, a total of 2961.75 qualified nursing hours were worked by bank and agency staff. We were also told that nursing staff from Dewsbury ED rotated to Pinderfields to gain experience and maintain skills; the rotation did not currently work both ways as the staff numbers at Pinderfields did not allow it, so this meant vacant shifts at Dewsbury from rotating staff were covered by agency nurses. Department managers hoped that the rotation would become a two-way process from September 2018.

Medical staffing

The trust reported the following medical staffing numbers from April 2017 to March 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE</th>
<th>Planned WTE</th>
<th>Fill rate</th>
</tr>
</thead>
</table>

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At our last inspection we found that medical staffing in the department was not always meeting planned staffing levels. There was a reliance on locum doctors to fill gaps in the medical rota.

All medical staff worked between Dewsbury and Pinderfields EDs

Consultant cover in the department was from 8am until 11pm on weekdays. Out of these hours, consultants were on call. This was less than the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. The consultant cover in the department on a weekend was from 9am until 4pm. Staff told us that consultants were readily accessible on call, willing to help and would attend the department when needed, with many staying over the end of their shift when the department was busy.

We looked at four weeks of consultant rotas and found that all clinical shifts appeared to be covered. Out of the 28 days we reviewed, 13 had at least one locum doctor working. Consultants also had designated non-clinical time.

We looked at three weeks of specialist registrar rotas (we requested four weeks but only received three from the trust) and of the 21 days reviewed (all shifts) two were uncovered.

We looked at four weeks of junior doctor rotas and of the 28 days reviewed (all shifts) three were uncovered; one of these days had two vacant shifts.

We were told that GPs were based in the department each Saturday and Sunday night from 6pm until midnight to provide extra medical cover.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 4.7% for medical staff in urgent and emergency care. This is better than the trust target of 9%.  
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 4.9% for medical staff in urgent and emergency care. This is better than the trust target of 12%.  
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 0.4% for medical staff in urgent and emergency care. This is better than the trust target of 4.8%.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the
correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

We looked at four weeks of medical rotas and out of the 28 days we reviewed, 18 had at least one locum consultant working. There were at least two locum doctors working on the specialist registrar rota for the three weeks we reviewed. We looked at four weeks of junior doctors’ rota and there were between one and four locum doctors working on each shift.

Staffing skill mix

During January 2018, the proportion of consultant staff reported to be working at the trust were about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 61-whole time equivalent staff working in urgent and emergency care at The Mid Yorkshire Hospitals NHS Trust.

![Staffing skill mix chart]

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

At our last inspection we found that record keeping in relation to NEWS and pain scores was not consistent. At this inspection we reviewed 10 sets of adult notes and found that NEWS was recorded in 7 out of 10 and pain scores were recorded in 7 out of 10.

Staff used a recognised pressure ulcer risk assessment tool, which was included in the nursing assessment notes. We looked at ten records in which a pressure ulcer risk assessment was appropriate for the patient, and seven had been completed. We looked at the ward manager’s audit for June 2016 and out of 10 patient records reviewed, all patients had skin/pressure ulcer assessments completed and documented.

The department used a combination of paper and electronic records. Paper records were scanned into the electronic system following patient discharge and paper records would then be stored for
three months. Patients’ past medical notes could be accessed immediately through the computer system.

All records we reviewed had been completed in a legible manner with staff names and designations clearly written.

**Medicines**

We found that medicines, including controlled drugs (CDs), refrigerated items and prescription stationery, were safely stored. CDs were managed safely and would always be signed out or checked by a band six nurse along with another qualified member of staff. CDs were checked daily by two qualified staff for expiry date and quantity, and monthly by pharmacy staff. During inspection we found one CD item that was out of date and had not been picked up during routine checks. We highlighted this with the nurse in charge and it was dealt with immediately. All other expiry dates and stock balances we checked were satisfactory.

Fridge temperatures were recorded electronically and monitored by the pharmacy department. It is essential that medicines are stored at the correct temperature to ensure they do not become ineffective or harmful. We checked the fridges and found an item of out of date medicine, which we highlighted to staff.

We found two bags of intravenous potassium solution stored in an unlocked drawer in the resuscitation room. Guidance states that all intravenous fluids should be locked away, with potassium stored separately, unless a risk assessment had been carried out for use on a resuscitation trolley. This was raised with the nurse in charge and was removed immediately.

We found emergency drugs boxes and anaphylaxis treatment packs to be sealed and labelled with the date of expiry. All were in date and maintained by pharmacy staff.

During inspection we were concerned that paper copies of Patient Group Directions (PGDs) had not been updated and signed by nursing staff other than ENPs. PGDs are required to enable nurses to administer certain ‘prescription only’ medicines without a prescription from a doctor. We were informed during inspection that if nurses' PGD paperwork was not up to date they would not administer medicines without a prescription from a doctor, but we could not be fully assured of this. Following inspection, we have been assured by the trust that an immediate review had been completed and a rapid improvement plan was in place to address this. All PGDs were having expiry dates reviewed and any that were out of date were being immediately acted upon. A senior nurse was appointed to attend the monthly PGD group and there was a plan to proactively review PGDs before they expired. The group would continue to meet until the action plan was completed. Packs of updated PGDs were being distributed to each clinical area requiring them, all staff who used them had to fill in a signature sheet and they were all then signed off by a clinical lead. There was a named Matron to ensure sheets were signed and staff competencies had been completed.

**Incidents**

Staff we spoke to knew how to report incidents; they were encouraged to do so, felt supported during the process, and received feedback. They found the online reporting system easy to use. We spoke to the department’s lead nurse who told us that incidents were usually reviewed by the nurse in charge who was on duty on the shift during which they were reported. Incidents were shared in a staff diary, by email and during handover, and staff were involved in looking at reasons incidents may have occurred and what could be learned. The clinical educator for the department used incident outcomes to influence staff education and training.
We looked at the incidents reported for the three months from April to June 2018. The most commonly reported incidents were pressure sores/decubitus ulcers, adverse events affecting staffing levels, abuse of staff by patients and incidents related to patient transfer, which were all in line with what staff had told us during our discussions.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke to were aware of the duty of candour and were able to explain it adequately to us, although none were able to give examples of when it had been applied.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria: Two

(Source: NHS Improvement - STEIS (May 2017 to April 2018)

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on
patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff were aware of policies and procedures and knew where to find them. However, when we checked the policies on the trust intranet we found some of them to be out of date. We saw at Pinderfields ED that staff had access to policies and procedures through clinical emergency medicine (CEM) books, but saw no evidence of this being used at Dewsbury. Following inspection, the trust has provided evidence to show that CEM Books is used across all three of its sites. Staff attended ED study days regularly, which provided updates on current practice, training and any other issues arising in the department. The same study day was repeated several times so all staff had the opportunity to attend.

The department did not participate in national RCEM audits. The trust informed us that, following AHR, it was found that there was a much lower number of cases presenting that were relevant to recent audits. However, learning and action plans were shared from the audits at Pinderfields. Local audits were carried out in the department, including triage assessment, pain management, NEWS recording, patient checklist use, falls prevention, pressure ulcer prevention, patient dignity and environmental checks. The department was 90-100% compliant in each of these areas. The audits were carried out by the matron from Pinderfields ED to prevent bias.

Staff used a recognised pressure ulcer risk assessment tool, which was included in the nursing assessment notes. We looked at 10 records in which a pressure ulcer risk assessment was appropriate for the patient, and 7 had been completed.

Staff in the ED were supported to care for patients presenting with mental health conditions by a psychiatric liaison team employed by the local mental health trust. Staff from the psychiatric liaison team had access to the mental health trust’s care records, so could identify if patients were known to mental health services and give details of community mental health input and current treatment regimes. This was done on a ‘need to know’ basis to help ensure patients presenting with mental health conditions at the emergency department received appropriate and continuous treatment. The psychiatric liaison team gave verbal information to emergency department staff but no written management plan was available.

We were concerned that paper copies of PGDs had not been updated and signed by nursing staff other than ENPs. We were informed during inspection that if nurses’ PGD paperwork was not up to date they would not administer medicines without a prescription from a doctor, but we could not be fully assured of this. Following inspection, we were assured by the trust that an immediate review had been completed and a rapid improvement plan was in place to address this. All PGD expiry dates were being reviewed and any that were out of date immediately acted upon. A senior nurse was appointed to attend the monthly PGD group and there was a plan to proactively review
PGDs before they expired. The group would continue to meet until the action plan was completed. Packs of updated PGDs were being distributed to each clinical area requiring them, all staff who used them had to fill in a signature sheet and they were all then signed off by a clinical lead. There was a named Matron to ensure sheets were signed and staff competencies had been completed.

**Nutrition and hydration**

We spoke to ten patients and six told us that they had been offered something to eat or drink. Two said they had not been offered anything, and the remaining two had only been in the department for a short time. We witnessed several patients being offered food and drink by staff and two patients who asked for drinks who were attended to immediately.

We reviewed 10 sets of patients’ notes and six had documentation completed to say they had been offered food or drink. We spoke to a housekeeper/porter, in the adult ED, who said that they would routinely check with staff which patients were able to eat and drink, and ask these patients whether they required anything. The housekeeper told us they were not responsible for documenting this in patients’ notes.

In the waiting room there were vending machines available for patient use, with healthy drink and snack options available.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

*(Source: Emergency Department Survey – September 2016)*

**Pain relief**

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.4 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.1 for the question “Do you think the hospital staff did everything they

*(Source: Emergency Department Survey - September 2016)*

We spoke to 12 patients and they all told us that staff had ensured they were comfortable. Six recalled having been specifically asked to score their pain. We reviewed 10 sets of adult patients’ notes and pain scores were recorded in 7 out of 10.

**Patient outcomes**

The department did not participate in RCEM audits, but learning and recommendations were shared from Pinderfields through clinical governance meetings. Local audits were carried out in the department, including triage assessment, pain management, NEWS recording, patient checklist use, falls prevention, pressure ulcer prevention, patient dignity and environmental checks. The department was 90-100% compliant in each of these areas. The audits were carried out by the matron from Pinderfields ED to prevent bias.

**Competent staff**
Appraisal rates

Trust wide

The trust target for staff appraisal completion rate was 85%. From April 2017 to March 2018, 78% of required staff across the trust’s urgent and emergency care services received an appraisal. Data provided to us following inspection showed the appraisal rate had increased to 95%, which showed a marked improvement. The trust was unable to provide site- or role-specific data. Staff we spoke to on inspection told us that their appraisal had been completed. They had found it helpful and felt supported in the process.

New staff starting work in the department had a six-week induction plan which had been devised by the clinical practice educator. Each week had specific objectives and clinical time was allocated to work with a specified preceptor; this is an experienced practitioner who provides supervision and guidance. We spoke to a staff member who had undergone the induction programme and they had found it very positive and supportive. All staff attended a regular ED specific study day providing information on current issues and clinical updates. We asked if there was any specific transfer training for nurses who escorted patients on ambulance transfers: none was currently available but we were told it was going to be included as part of the arrest course.

The department had a clear education strategy in place, with objectives for each level of nursing and care support staff. We were told that funding was not available for nursing staff to complete the ALS or TNCC courses; the department had attempted to mitigate this by devising an ‘arrest course’ for staff in which they were presented with various patient care scenarios to manage, and which involved a board game to encourage learning and improve staff engagement. The department also accessed the Trauma and Resuscitation Team Skills (TARTS) course and training from external providers, for example medical technology companies, also took place.

Mental health training was not mandatory for nursing staff although some ad-hoc training was available, provided by the psychiatric liaison team (PLT). There was a care certificate course for new healthcare assistants (HCAs) which had a component, delivered by the PLT, around the management of challenging behaviour.

We discussed major incident training within the department with senior staff. They told us that respirator mask fit testing was ongoing, and that a rolling program was being established to update staff in the use of decontamination equipment, as some aspects of this training were out of date. The department also aimed to include ENPs and staff from the children’s department in major incident training.

The children’s department had a practice facilitator and there was an action plan in place to ensure children’s nurses were appropriately qualified and experienced. We saw evidence of a clear education plan for the year ahead. Data provided to us by the trust showed that 73% of eligible paediatric ED staff across the trust were compliant with Paediatric Immediate Life Support (PILS) training and 60% were compliant with European Paediatric Advanced Life Support (EPALS). The trust target was for 85% training compliance by February 2019, and we were informed that 100% of eligible staff had been enrolled on courses. There were two registered children’s nurse on duty in the children’s ED apart from between 7am-9.30am when there was one. This does not meet national guidance which says there should be two trained staff at all times.

The department had a local induction process in place for agency staff and it was possible for them to have access to systems such as the computer databases. We were told that often the same agency staff returned to the department, so were familiar with the environment, policies and procedures.
The trust’s ENPS rotated across the three hospital sites and told us this was useful to provide insight into issues and challenges in the different areas. There were 28 ENPs employed, nine of which were independent prescribers. The other ENPs all had up to date PGDs and this was monitored by the trust ENP lead. Appraisals were also up to date.

Nursing staff told us they were well supported through revalidation completion. Revalidation is the process that all nurses and midwives in the United Kingdom need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing.

**Multidisciplinary working**

We observed good examples of teamwork within the department; doctors, nurses and other healthcare professionals working well together to support each other and to provide effective patient care. There was good communication and staff we spoke to told us they felt part of a team. Board rounds were held twice daily in which senior medical and nursing staff went around the department and discussed current patients, issues and concerns.

We spoke to ENPs who told us that they had good working relationships with other specialities that they referred patients to. They gave examples of these teams providing support and training to staff.

We witnessed good examples of team working between the adults’ and children’s departments, and were told by staff in the children’s ED that they also worked effectively with staff on the children’s assessment unit (CAU). The CAU at Dewsbury was open from 10am until 10pm and nursing staff rotated between here and the children’s ED. Children’s nurses would attend the resuscitation room should an unwell child attend the department, and a nurse from the adult ED would cover for them.

We observed good examples of communication between consultants and junior doctors: on two occasions consultants were heard to be giving feedback and it was done in a professional and respectful manner.

Staff in the emergency department received specialised support from the psychiatric liaison team which consisted of registered mental health nurses. The psychiatric liaison service worked 24 hours a day, 7 days a week with all adult patients who presented to the emergency department. They were based within Pinderfields and Dewsbury hospitals during the day and were based at Pinderfields hospital at night. Staff in the psychiatric liaison team and emergency department highly valued each other’s input and commented that the services worked well together to meet patients’ physical and mental health needs.

**Seven-day services**

The ED was operational 24 hours a day, seven days a week, and access to services such as X-ray/CT scanning facilities, pharmacy and pathology was available at all times, either through direct referral or on-call. There was 24 hour a day access to PLT for adults, which we were told was very responsive, but staff indicated that the child and adolescent mental health service (CAMHS), which was provided by a local mental health trust, provided an out of hours on call service which was not as responsive.

**Health promotion**
We saw posters in the waiting room giving advice to patients about taking antibiotics unnecessarily. There was information available in the department about smoking cessation services and access to alcohol liaison teams. We saw information leaflets for patients, for example giving advice about aftercare following treatment, and these could be accessed in other languages. Discharge advice was given to patients / carers to allow patients to safely manage their condition at home or where to seek further advice if appropriate. In the children’s ED there was information available about breastfeeding, tooth brushing and measles.

Healthy drink and snack options were available to patients in the waiting room vending machines.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

We were told by staff that verbal consent was routinely obtained from patients but would not usually be documented. We witnessed staff explaining procedures to patients and gaining their consent verbally. Staff told us that they would document if a patient refused to provide consent or if they did not have capacity to make a decision, and this would be escalated. Some staff we spoke to were not able to adequately explain the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in relation to their role. We reviewed 10 sets of adult patient notes and one had the patient’s lack of mental capacity recorded, but there was no evidence of further assessment. In the other sets of notes, six stated that a capacity assessment was not applicable and the other two had not been completed.

Staff in the emergency department received specialised support from the psychiatric liaison team which consisted of registered mental health nurses. The psychiatric liaison service worked 24 hours a day, 7 days a week with all adult patients who presented to the emergency department. They were based within Pinderfields and Dewsbury hospitals during the day and were based at Pinderfields hospital during the night. Staff within the psychiatric liaison team and emergency department highly valued each other’s input and commented that the service worked well together to meet patients’ physical and mental health needs.

**Mental Capacity Act and Deprivation of Liberty training completion**

MCA and DoLS (combined) level 1 training was part of the trust’s mandatory training programme, to be completed three yearly, with a compliance of 95%. Data provided to us by the trust showed that in urgent and emergency care training compliance was 99%

MCA and DoLS levels 2 and 3 were part of the trust’s role specific training programme, both to be completed every three years with a completion target of 85%. Data provided to us by the trust showed that, in urgent and emergency care, level 2 compliance was 77% and level 3 compliance was 52%. The trust was unable to provide role or site-specific data.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from April 2017 to March 2018.

In March 2018 the trust performance was 94.6% compared to the England average performance of 84.3%.
We observed many interactions between staff, patients and others (for example carers and relatives) during our inspection. At all times we found staff to be polite, respectful, professional and non-judgmental in their approach. All staff grades were seen to introduce themselves to patients, and to ask what the patient preferred to be called. We observed staff responding to patients’ needs in a compassionate and timely manner; the patients we spoke to all had call bells available and those that had needed to summon assistance said they had not had to wait long before a member of staff attended. Staff closed the curtains and doors of cubicles when patients were receiving care and treatment. We were told that beds were brought to the department for patients waiting for transfer.

We found friends and family test information readily available around the department, and separate information was also available in the children’s ED. We witnessed staff asking patients to complete the survey and providing them with the relevant information.

**Emotional support**

We observed staff providing effective emotional support to a patient who was anxious about their treatment and worried about being transferred to another hospital. We observed a staff member speaking with a distressed patient who wished to self-discharge: the staff member remained calm and reassuring, and explained to the patient why they would prefer them to remain in the department to wait for test results. The patient became calmer and agreed to stay, and apologised to the staff member for their behaviour.

There was a bereavement service available within the hospital who provided follow-up care to relatives/others and gave information and advice. Information leaflets were available in other languages from the bereavement office. The department had a private room in the main
department which could be used by people such as family and friends of patients in the resuscitation room.

Understanding and involvement of patients and those close to them

We spoke to 10 patients and four relatives, and all said they had felt involved in their care and were helped to make informed decisions. Patients told us that staff had made sure they understood what was happening and kept them updated during their time in the department, for example if they were waiting for further assessment, test results or ambulance transport. We observed nursing and medical staff explaining procedures to patients clearly and using appropriate language, whilst remaining respectful. Advice was given to patients when they were discharged and we observed nursing and medical staff ensuring this was understood by patients and relatives.

Emergency Department Survey 2016

The trust scored “better than” other trusts for none of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored “worse than” other trusts for one question and “about the same” as other trusts for the remaining 23 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
### Question

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>respect and dignity while you were in the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

### Is the service responsive?

**Service delivery to meet the needs of local people**

Following the reconfiguration of services, the ED at Dewsbury did not accept patients by ambulance with acute or complex needs; these patients were transported to Pinderfields Hospital. Patients who self-presented to Dewsbury would be transferred to Pinderfields if they required admission to a ward. Staff told us that many patients had said they were unhappy about this as they lived in or near to Dewsbury and would have preferred not to travel to Wakefield. Patients could be admitted to the medical ward at Dewsbury if their needs met the relevant criteria, but staff told us this was a frailty unit and was typically not appropriate for the needs of the local population. There was a free hospital shuttle bus providing transport between the trust’s three hospital sites.

Staff told us that many patients had said they were under the impression that the ED at Dewsbury had closed following the reconfiguration of services, so attempts were made to raise awareness of...
the local population about the department and the services it still provided. For patients who attended Dewsbury and then required admission to Pinderfields, information packs were available giving details of their care, so they were well informed and knew what to expect on arrival.

Local people attending the ED with mental health needs were referred to the psychiatric liaison service, who aimed to attend within an hour of referral, but mental health services for children and young people in the local area were less responsive. The psychiatric liaison service was commissioned by the local clinical commissioning group as part of the mental health contract. The service specification set out the level of support to be provided to the trust. It included support to adults of all ages including older people, but not children and young people.

Staff from the emergency department, along with the psychiatric liaison team, police and other services, met regularly to discuss supporting people who frequently attended the emergency department, including patients with mental health needs. Staff also looked at redirecting patients from the emergency department if their needs could be better met elsewhere in the health and social care system. For example, a patient was re-housed in supported accommodation to meet their social needs, with the aim of preventing inappropriate attendances to the emergency department.

**Meeting people’s individual needs**

Patients who attended the department who were known to be living with dementia or learning disabilities were flagged on the computer system. The VIP scheme was used to identify and support patients with learning disabilities; this was a system used to ensure staff were aware of important patient information and requirements. Patients living with dementia were identified by a butterfly symbol, and a ‘forget-me-not’ sticker was added to their notes to alert staff that extra support may be needed. The trust employed liaison nurses for learning disabilities and dementia, and staff could refer to them for advice or additional support for patients. The ED at Dewsbury had three ‘dementia friendly’ cubicles in the majors’ area, which had large wall clocks showing the time and date, and colourful wall displays showing the seasons, which were changed during the year. Distraction aids were available for use by patients to help minimise agitation and anxiety. There was a range of information available in the department and details of support and social groups that patients could attend with their relatives/carers. Staff told us they would assess patients on an individual basis and, if possible, alongside their relatives/carers, to decide the best place to care for them and the best approach to take.

Interpretation services were available for patients by telephone, and we saw posters around the department and in the waiting room giving information about this service. We were told that the staff group in the ED was quite diverse and often there was a staff member on shift who would be able to translate; we saw evidence of this happening during our inspection. Patient advice leaflets could be requested in other languages and formats, including a ‘read aloud’ version. We were not made aware of any other communication aids available, and it was not apparent that patient flagging occurred for those with communication needs.

The department was accessible for people with mobility problems or those using wheelchairs. Accessible toilets were available. The department had access to bariatric equipment, including a bed, chairs, wheelchairs and hoist.

**Emergency Department Survey 2016**

The trust scored “about the same as other trusts” for the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Q7. Were you given enough privacy when discussing your condition with the receptionist? 7.0 About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last? 7.1 About the same as other trusts
Q20. Were you given enough privacy when being examined or treated? 9.0 About the same as other trusts

(Source: Emergency Department Survey - September 2016)

Access and flow

Staff told us that they felt the department had changed since AHR and they saw far fewer ambulance patients. We spoke to two ambulance crews who told us they very rarely transported patients to Dewsbury ED, most times they visited the department were to transfer patients to Pinderfields. The crews told us they had ‘What patient where?’ guidance so they knew the admission criteria for each hospital.

We spoke with the patient services manager, who was based at Pinderfields but attended Dewsbury hospital on a weekly basis. They had daily oversight of the department from an operational perspective alongside clinical leads and looked at quality, performance and risk. We were told there were four divisional operational meetings each day at Pinderfields to discuss these issues and to plan where support was needed. A daily operational performance meeting took place each morning, with teleconference links to Dewsbury, which was attended by each division to assess issues of capacity, demand and operational challenges.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for eight months over the 12-month period from April 2017 to March 2018.

From April 2017 to March 2018 performance against this standard showed performance similar to the England average.

In March 2018 the median time to treatment was 65 minutes compared to the England average of 64 minutes.

Median time from arrival to treatment from April 2017 to March 2018 at The Mid Yorkshire Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)
We reviewed 16 patients’ records and noted the amount of time from arrival to treatment. Eight patients were seen within one hour by a doctor. A further seven patients were seen within two hours. One patient waited more than two hours to be seen by a doctor.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From April 2017 to March 2018 the trust failed to meet the standard and performed worse than the England average for nine of the 12 months in this period.

From April 2017 to March 2018 performance against this metric showed no consistency and a gradual decline in performance.

**Four-hour target performance - The Mid Yorkshire Hospitals NHS Trust**

We reviewed 16 sets of patients’ records and nine were admitted, transferred or discharged within four hours. Of the remaining seven, two waited between four and seven hours, three waited seven to ten hours and two were in the department between ten and twelve hours.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From April 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From April 2017 to March 2018 performance against this metric showed little consistency but an overall increase in the percentage of patients waiting by the end of the period.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - The Mid Yorkshire Hospitals NHS Trust**
We looked at 16 patients' records during our inspection; ten of these patients were admitted to hospital and required transport to Pinderfields Hospital. Five waited more than four hours from the decision to admit until being admitted; the waits were all due to ambulance transfer delays.

### Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from April 2017 to March 2018, three patients waited more than 12 hours from the decision to admit until being admitted. The only patients waiting over 12 hours were in May 2017 and December 2017 and February 2018.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>367</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>1,037</td>
<td>1</td>
</tr>
<tr>
<td>Jun-17</td>
<td>684</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>1,020</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>1,146</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>835</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,144</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>481</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1,414</td>
<td>1</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1,943</td>
<td>0</td>
</tr>
<tr>
<td>Feb-18</td>
<td>772</td>
<td>1</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1,563</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E waiting times)

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment
From April 2017 to March 2018 the monthly median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

From April 2017 to March 2018 performance against this metric showed a stable trend.

In March 2018 the median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 4.1%, compared to the England average which was 3.3%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - The Mid Yorkshire Hospitals NHS Trust

![Graph showing percentage of patients leaving urgent and emergency care services before treatment](Image)

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From April 2017 to March 2018 the trust’s monthly median total time in A&E for all patients was similar to the England average.

From April 2017 to March 2018 performance against this metric showed a small increase in the median total time in A&E per patient.

In March 2018 the trust’s monthly median total time in A&E for all patients was 152 minutes compared to the England average of 160 minutes.

Median total time in A&E per patient - The Mid Yorkshire Hospitals NHS Trust

![Graph showing median total time in A&E per patient](Image)
Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 176 complaints about urgent and emergency care services. The trust took an average of 27 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 days.

The four most common subjects of complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Percentage of total complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>61.4%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>19.9%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>6.3%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018 there were 32 complaints about urgent and emergency care services at Dewsbury & District Hospital.

The four most common subjects of complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Percentage of total complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>56.3%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>18.8%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>12.5%</td>
</tr>
<tr>
<td>Admin/policies/procedures (inc patient record)</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From April 2017 to March 2018 there were 110 compliments in urgent and emergency care.

<table>
<thead>
<tr>
<th>Name of hospital</th>
<th>Total number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dewsbury &amp; District Hospital</td>
<td>43</td>
</tr>
<tr>
<td>Pinderfields Hospital</td>
<td>59</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We saw information displayed in the department giving details of the patient advice and liaison service (PALS) and informing patients how to make a complaint if they wished to. Staff we spoke to told us how they would handle a complaint or concern and told us that complaints had been shared with staff to learn from them.

Complaints received through PALS were passed to the clinical governance team, and all complaints were handled by the department matron. As with incidents, complaints were discussed at local governance meetings and shared with staff to influence learning and education.

Is the service well-led?

Leadership

Staff told us that the department management team was approachable and supportive, and that there was a visible management presence in the department. Staff also commented that the hospital senior management team had visited the department and discussed concerns with them.

The nursing team in the department was led by experienced staff who provided clinical and professional supervision. There was an education strategy for the department which gave clear objectives for staff at every level, and this included development of leadership skills for more experienced staff.

We observed clear leadership in the department’s medical team; on several occasions we witnessed junior doctors being supported by more senior colleagues and consultants, with teaching discussions taking place and feedback and advice being given. We spoke with junior doctors who told us they were happy with the leadership within the department and they felt well supported.

Vision and strategy

The trust’s vision and values were clearly displayed in the department. When we asked staff about the strategy for the department they were unable to tell us. This included senior staff.

Culture

The staff we spoke to told us that the culture in the department was open and inclusive; staff felt valued and respected, and wanted to be there. Some staff told us that morale had been quite low following AHR but that things were improving and that they had all supported each other and worked well as a team. We were told that some staff had left the department and others had
expressed concerns that they would become deskilled and not gain enough experience following the changes.

The senior staff spoke very highly of their team and were clearly proud of them; they commented that staff in the department achieved a lot ‘on a shoestring’ and had a ‘grow, learn and do’ attitude. We witnessed positive examples of teamwork and support during our inspection. Staff told us that they regularly socialised together and that the department was ‘close-knit’ and friendly.

**Governance**

The ED was part of the medical directorate, which had clear governance structures with an assistant head of nursing, head of clinical service and assistant director of operations. There was a consultant lead for governance at Dewsbury ED. Each speciality within the directorate had a designated governance lead; regular meetings ensured that information was shared with each area and fed up to the quality committee, patient safety panel and trust board as necessary. The ED had monthly clinical governance meetings, with a telephone conference link between the three hospital sites, to which all staff were invited. These meetings provided an opportunity to discuss issues such as patient safety and risk management and to present information to the teams, such as the latest audit information and guidance.

The trust had signed up as a partner agency to the local mental health crisis care agreement and action plan for the Wakefield area. This was a national agreement between services and agencies involved in the care and support of people in mental health crisis. It set out how organisations would work together better to make sure that people got the help they needed when they were having a mental health crisis.

We were not assured that senior staff had adequate oversight of the systems and processes used to check emergency equipment and medicines, although when we raised issues during our inspection they were addressed immediately.

**Management of risk, issues and performance**

The department had a clear business management plan and operational pressures escalation policy, which gave detail of ‘normal’ business management and the actions to be taking when service demand was increased.

There was a patient services manager for urgent and emergency care, who was relatively new in post at the time of our inspection, and had oversight of the three hospital sites looking at quality, risk and performance alongside the senior management team. There was a daily operations meeting which looked at bed availability, concerns and actions that needed to be taken. This took place at Pinderfields with a teleconference link to Dewsbury.

We were told during the inspection that the department was still a receiving site for trauma patients following a major incident. Staff were concerned about this due to changes within the hospital following AHR, such as reduction in operating theatre capacity and critical care services, and also because many felt the department was in a high-risk area due to nearby motorways and local industry. We informed by senior staff that the trust was reviewing the major incident plan post AHR.

We asked senior staff what the main risks were in the department, and they told us that patient transfer delays, security in the department and pressure ulcers were the biggest risks. Following our inspection, we looked at the department risk register dated 31 July 2018 and this supported
what we had been told, with the addition of adverse events affecting staffing levels, which was the second highest reported risk.

We had concerns during our inspection about patients who had long waits to be transferred to Pinderfields. Delays in ambulance transfer response times were on the risk register and had been escalated. Ambulance service activity was being monitored daily.

Regarding security in the department, we were told there were often incidents with violent or aggressive patients. The team was looking at ways in which access to the department could be restricted overnight, as it is open to the main corridor of the hospital. They were also considering the use of closed-circuit cameras and a protective screen at the reception desk for additional security. Security staff were available in the hospital 24 hours a day, seven days a week.

**Information management**

The department collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The information was used to monitor the performance of the department. Information governance training was part of the trust’s mandatory training programme, to be completed on a yearly basis and with a 95% compliance target. Data provided by the trust showed that compliance for urgent and emergency care staff was 70% across the three hospital sites.

During our inspection we had concerns relating to the management of sensitive information. We found several computers in the department which had not been locked by the previous user and patient information was visible when the screens were activated; one was in the resuscitation room, which could be easily accessed from the main corridor without the knowledge of staff if the room was not in use.

We were informed during inspection that the reception staff worked across all three hospital sites and because of this had mistakenly booked patients in as being at the wrong hospital. We were told this had always been quickly highlighted, and had never caused issues or been reported as an incident.

**Engagement**

The staff we spoke to provided mostly positive feedback about their roles and about the department in general. However, staff of all levels stated that there had been a lot of changes following AHR which had affected morale of staff. It was generally felt by those working in the department that morale had started to improve; staff appeared engaged in department activities, and told us they were involved in meetings, social media groups and social events.

We saw information around the department relating to the friends and family survey, and witnessed patients and relatives completing the survey whilst they were in the department. ‘You said, we did’ information was displayed, which showed changes that had been made following suggestions from patients.

**Learning, continuous improvement and innovation**

The department had appointed a clinical educator, who was relatively new in post at the time of inspection, who we spoke to about improvements in training and education within the department. We were told that the previous challenges had been recognised and there was now more emphasis on the importance of training. The department had a clear education strategy in place,
and learning from incidents and complaints was embedded. Staff told us that access to training had improved and they felt better supported to learn and develop their skills.

We were told that a senior nurse and consultant at Dewsbury ED had been responsible for the development of the ‘arrest course’ to help staff learn and develop their resuscitation skills and care for deteriorating patients. The course included use of a board game and this had been highly commended, winning an award at the trust’s ‘celebrating excellence’ award ceremony.

### Medical care (including older people’s care)

#### Facts and data about this service

The Mid Yorkshire Hospitals NHS Trust delivers medical care including older people’s care at three hospital sites. Medical care across all three sites is managed within the Division of Medicine. There are 693 medical inpatient beds located across three sites and 26 wards/units.

A site breakdown can be found below:

- Pinderfields Hospital: 494 beds are located within 19 wards/units
- Dewsbury and District Hospital: 157 beds are located within six wards/units
- Pontefract Hospital: 42 beds are located within one ward/unit

(Source: Routine Provider Information Request – Sites tab)

The trust flow pathway sees patients transfer out to Dewsbury and District Hospital (DDH) and Pontefract Hospital once patients are deemed medically stable. However, there is direct access to a frailty unit on the DDH site for the benefit of the local population. The trust currently runs emergency ambulatory care services from both Pinderfields Hospital and DDH.

(Source: Routine Provider Information Request AC1 - Acute context)

The medical services offered at DDH include: an ambulatory care service for people who need rapid assessment, tests and treatment but don’t need to stay in hospital; rehabilitation for people with neurological conditions and stroke; a frailty unit (Acute Care Elderly, ACE) which is a dedicated service for elderly care focusing on rapid assessment, treatment and helping people get back home if they are well enough and ‘step down’ care / rehabilitation for people who are recovering after a period in hospital, step down care is also provided for elderly patients recovering from orthopaedic surgery.

The trust had 71,024 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 33,778 (47.6%), 786 (1.1%) were elective, and the remaining 36,460 (51.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 17,571
- Gastroenterology: 10,966
• Geriatric medicine: 9,183

(Source: Hospital Episode Statistics)
Is the service safe?

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed their training. Staff were required to complete core and role specific mandatory training in topic areas such as health and safety, infection control, manual handling and information governance.

Staff told us that they could access training sessions and could attend a full day of mandatory and statutory training which covered several topics.

**Mandatory training completion rates**

The trust set a target of 95% for completion of core mandatory training and 85% for completion of role specific mandatory training.

Information provided by the trust on 30 June 2018 showed that the overall compliance rates with core mandatory training for staff working in medical care services were 89% which did not meet the trust target of 95%.

For role specific training, overall compliance rates were 76% which did not meet the trust target of 85%.

**Trust level**

**Core Mandatory and Statutory Training (MAST) Compliance (target 95%)**

<table>
<thead>
<tr>
<th>CORE SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Diversity Awareness - Once in Employment</td>
<td>59</td>
<td>1538</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Infection Control - Every 2 Years</td>
<td>266</td>
<td>1331</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 1 Theory - Every Three Years</td>
<td>129</td>
<td>1468</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 1 - Every 3 years</td>
<td>12</td>
<td>1585</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Fire Safety - 1 Year</td>
<td>422</td>
<td>1175</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Health and Safety Level 1 - 3 Years</td>
<td>92</td>
<td>1505</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>416</td>
<td>1181</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>109</td>
<td>1488</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>96</td>
<td>1501</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1601</td>
<td>12772</td>
<td>14373</td>
<td>89%</td>
</tr>
</tbody>
</table>
Role Specific Compliance (target 85%)

Ward managers received ‘Heatmap data’ which included mandatory training compliance levels for their ward. At June 2018 the overall compliance for core mandatory training for ward 6 was 94%, 6b (8) was 90%, ward 10 was 88% and ward 15 was 80%. At June 2018 the overall compliance for role specific mandatory training was 79% for wards 10 and 6b, 75% for ward 6 and 66% for ward 15.

Safeguarding

Staff had a good knowledge and understanding of the trusts safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff knew how to contact the safeguarding team for advice and had access to the team’s details on the intranet. Information on safeguarding with flowcharts for staff to follow were available on the intranet.

Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children.

Staff told us that the Mental Health Act was rarely used. Their understanding of the Act was not clear and some staff confused it with the Mental Capacity Act 2005.

Safeguarding training completion rates

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module.

(Source: Additional Data Request ALL2)
Trust level

The trust provided a breakdown of compliance on 30 June 2018 for safeguarding training modules for staff working in medical care.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>1501</td>
<td>1597</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>1488</td>
<td>1597</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>1045</td>
<td>1267</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>1021</td>
<td>1256</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 3 additional)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

For staff in medical care services the compliance target was not met, however it was very close to the target in four out the five training modules.

(Source: Additional Data Request ALL2)

Cleanliness, infection control and hygiene

The service controlled infection risk well. All ward areas we visited appeared visibly clean and all equipment we inspected was clean.

We saw that personal protective equipment such as gloves and aprons, were available for staff and used appropriately. Handwashing facilities and alcohol gel were available in each bay and side-room. We saw staff washing their hands and they adhered to the trust policy of bare below the elbows.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door.

Infection control audits (FLO audits) were carried out monthly and the results were shared with the ward manager and nursing staff. For the medical wards we saw that these audits were carried out monthly on most wards and compliance was over 95% (green) with only one exception on ward 10 from January 2018 to June 2018. However, there was no data for ward 10 in April and May 2018 and a gap in data for ward 15 June 2018.

Staff were required to attend infection control training as part of their mandatory training. Compliance for the division of medicine was 83% the end of June 2018. In addition, relevant staff received aseptic non-touch technique (ANTT) training, however we did not receive compliance data specifically for this topic. ANTT practice was audited monthly and audits from April 2018 to June 2018, on the medical wards 6, 6b (8), 10, 15 and 20 (CDU) showed that aseptic non-touch technique (ANTT) compliance was regularly below the expected standard of 95%.

There were three sharps bins on the ambulatory care unit incompletely labelled.

The division of medicine had identified an increase in the number of cases of Clostridium difficile. From April 2018 to July 2018 there had been nine trust attributable cases in the division. Three of these cases were at Dewsbury, two cases had occurred on ward 15, and one on ward 6b (8).
was above the target trajectory and an action plan to reduce the number of cases was being led by the infection control team.

Patients on ward 10 told us the ward was spotlessly clean.

Environment and equipment

All wards we visited were tidy, well organised and visibly clean. Cleaning was in progress in the areas we visited with safety signage displayed.

At the last inspection we found extra capacity beds in ward areas which were cramped and patients did not have correct furniture or a call bell. At this inspection we found no extra capacity beds.

Wards had a number of bedded bays and side rooms. All bays were single sex and beds all had oxygen, suction, call bells and lockable storage for patient use. There were accessible toilets and bathrooms on all the wards we visited.

We checked equipment which included hoists, blood pressure monitors and chair scales. We found they were in good working order and had been safety tested and checked according to manufacturer’s recommendations. The exception to this was the defibrillators and suction machines on the resuscitation trolleys which were due for maintenance checking in May and June 2018. We queried this with the trust who informed us that there was a 60-day period of grace built into the review dates which meant the equipment was not yet overdue and was scheduled for checking in July.

Equipment had been labelled with ‘I am clean’ stickers, with the date the equipment was last cleaned. Resuscitation trolleys had been checked daily by staff on all wards we visited. However, there was dust on the resuscitation trolley in the discharge lounge and there was no service date on the suction machine and defibrillator.

Staff told us that equipment for the management and prevention of pressure ulcers was readily available.

On ward 6 we found razors and hand sanitiser (large refill bottles) were stored in the assisted bathroom in an unlocked cupboard, which posed a potential risk to patients. The corridor on this ward was generally cluttered with equipment and trolleys. The door to the storeroom was also open.

The dirty utility room on ward 10 was unlocked and we found unsecured oxygen cylinders outside a patient bedroom.

On ward 15 we saw that patient names were displayed clearly above beds. Not all call bells were within reach of patients, however, we noted staff were present in the bay writing up notes. There was a bespoke trolley on this ward with equipment needed in the case of Sepsis. The ward was light, bright and uncluttered. There was a dining room for patient use on this ward.

A gym / activity room was available on ward 10 to support the rehabilitation of patients.

There was no TV or radio in the discharge lounge and only a single emergency buzzer in the communal area.
Assessing and responding to patient risk

Measures were in place to ensure that staff assessed and responded to patient risk.

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. Nursing staff recorded patient observations and entered them onto a hand held electronic clinical record system, which calculated the patients NEWS. The electronic system alerted nursing staff if the patient’s NEWS changed and if action needed to be taken. Nurses told us that if patients deteriorated and became unwell that doctors responded promptly. Heatmaps for wards 6, 6b, 10 and 15 indicated that observations recorded on time was audited monthly and that from January 2018 to June 2018 compliance was consistently above 85% (green).

Ward 15 had achieved the gold award for deteriorating patients by ensuring that more than 85% of patient observations were done on time for 32 consecutive weeks.

Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk.

Staff updated risk assessments for falls, pressure damage and nutrition weekly. The Trust had introduced a process were staff were encouraged to reassess all patients for nutritional risk on Monday, pressure risk on Wednesday and falls risk on Friday.

The trust had a falls work stream to reduce the number of falls with harm. Falls safety cross displayed on the wall. We saw that patients at high risk of falling were nursed as cohorts in identified bays wherever possible. Staff tried to use bays close to the nurses’ station and safety support staff (Band 1) were available to provide one to one support to patients identified with a high risk of falling. Wards we visited used a tagging system where a member of staff was allocated to the bay and did not come out of the bay without ensuring they were replaced by another member of staff. This was to ensure patients at high risk of falling were supervised at all times. Staff recognised that the tagging system was not totally fail safe as they sometimes needed to pull the curtains around a patient to help with personal care and one member of staff told us how a patient had fallen when they were behind curtains with another patient.

We saw that some nurses sat in bays to do paperwork which helped with supervision. Desks had been sourced for some of the wards / bays to facilitate this.

There was ongoing work across the trust to reduce pressure damage and all nursing staff had received or were to receive ‘react to red’ training. Patients at risk of pressure damage were given a pressure ulcer prevention assessment and care plan. The ward manager on ward 6b (ward 8) showed us a react to red board they developed to show clocks for each patient which displayed the individual time each patient needed their next pressure relieving intervention/ check. The clocks were reset each time an intervention occurred to the time the next intervention was needed. The manager told us the use of the board had meant moving away from the more task oriented approach of comfort rounds which they felt had become ritualistic and perhaps not completed as they should. Since implementation of the board the incidence of pressure ulcers on the ward had fallen. The manager on ward 15 had asked staff to use skin assessment documentation rather than intentional rounding forms whenever they took pressure relieving action or checks and undertook mini root cause analysis investigations on every new or deteriorating pressure ulcer. The ward manager told us they had seen the incidence of pressure ulcers improve since implementing these measures. The ward had only one incidence of a category 2 ulcer in May and June 2018, there were no incidences of category 3 or 4 in the last two months.

Patients should be screened within six hours of admission for risk of venous thromboembolism (VTE). This was audited monthly by the division and the results were included in the divisional dashboard. The year to date results in the dashboard were 91%.
A sepsis screening tool was included in the admissions pack in all patient records. There was a section for nursing staff to complete with a clear escalation process for staff to follow. Not all wards had a specific sepsis trolleys, but staff told us they felt equipped to deal with sepsis quickly on the ward. Think delirium posters and signs of sepsis posters were displayed in clinical areas to raise staff awareness.

Wards displayed how many days they had been free from patient harms which included; falls, pressure ulcers and days without a clostridium difficile infection. They were rewarded with a bronze, silver or gold certificate if they achieved a specific number of days free from a patient fall.

There was an assessment tool that staff could use to identify and assess patients with possible mental health conditions. The assessment tool recommended action staff should take depending on patient’s initial mental health assessment and associated risk.

Staff told us when they referred patients to the psychiatric liaison service, they responded in a timely manner. However, in the records we looked at we did not see clear formulations of risk or risk management plans that would provide guidance for ward staff.

Staff told us they received safety briefings morning and evening.

One issue raised by staff was that transfer / handover information from Pinderfields Hospital was not always adequate and that although medical notes were usually fine, the transfer document was not always completed and pre-transfer information/ communication with the ward was not always good. One staff member gave an example of receiving a patient that they had no name for and that they had received information regarding a patient telling the receiving ward a patient was blind but they were not.

**Nurse staffing**

We had concerns about the level of registered nurse staffing on wards. Fill rates for registered nurse staffing in the day were low on most wards.

Overall unfilled shifts for qualified nurses in the division of medicine from April 2017 to March 2018 ranged from approximately 12% to 18% (see graph below).

The trust has reported their staffing numbers below as at March 2018 for medicine:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at March 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mid Yorkshire NHS Trust</td>
<td>708.5</td>
<td>582.9</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
The trust used the safer nursing care tool to calculate the ward staffing levels. This considers the acuity and dependency of patients on the ward. Ward managers told us that there was an 8.30am call to Pinderfields every morning to discuss daily staffing. Staff told us that acuity scores were sent to matrons twice a day but they didn’t get feedback or see any analysis in relation to this.

Staff told us that staffing levels were still an issue and more staff were needed on the medical wards. Staff commented that it was more difficult to get bank or agency staff during the day than at night.

During the inspection we saw on Ward 6 that the planned staffing level for RNs was 3 RNs during the day and this was available, however the monthly ward unify staffing information indicated that there was a 77% RN fill rate and 115% HCA fill rate on average in month. On ward 6b the planned staffing levels were met and the fill rates were around 90% for RNs day and night and HCAs at night. The fill rate for HCAs during the day was 117%.

The average fill rates from April 2018 to June 2018 on the medical wards at Dewsbury for registered nursing staff during the day ranged between; 64% and 89.3% for ward 10, 77.4% to 90.4% for ward 6, 77.2% to 85% for ward 6b (8) and 66.6% to 77% for ward 15.

The ward manager on ward 15 told us that planned staffing was three registered nurses (RNs) and two HCAs on a day shift and two RNs with three HCA’s at night. They told us that planned staffing levels were usually met and that they were currently overstaffed with HCAs. There were five RN vacancies which was mitigated to some extent by over-recruitment to HCA roles and shifts. Bank and agency staff were used on the ward and the ward was given priority for this due to the high number of RN vacancies. There were three Band 6 nurses on ward 15 to ensure senior staff were on duty over seven days.

The ward sister on Ward 6b told us that planned staffing is three RNs and four HCAs plus two safety support workers. There were 1.32 wte RN vacancies but 1wte was due to start in September. There were no HCA vacancies but there were 3.52 safety support worker vacancies. Vacancies in this area were compounded by a number of staff being on long-term sick leave. The ward manager told us it was a challenge to cover short term sickness but the members of the team often swapped shifts to help cover this.

Ward 10 did not have any vacancies for RNs because the ward leadership team had reviewed their staffing workforce in light of recruitment issues. The ward establishment plan now included band 3 trainee nursing associates to meet the needs of the patients.

The discharge lounge was staffed by one RN and one HCA. If a second nurse was needed for any reason the staff could get support from the adjacent infusion unit. If there was no RN cover available for the discharge lounge due to short notice absence then the patients would be taken to the elderly assessment unit or ambulatory care. Patients needed to meet defined criteria for acceptance onto the discharge lounge and a form needed to be completed by the wards to ensure only patients who met the criteria were sent.

Other support staff on the wards included housekeepers and discharge co-ordinators.

We saw student nurses on the wards who were they are clearly identifiable. Students told us they were well supported and were never asked to undertake duties they felt inappropriate to their role.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 14.3% in medicine, compared to the 9% trust target.

(Source: Trust Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.4% in medicine, compared to the 12% trust target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 5.3% in medicine, compared to the 4.8% trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The below table shows total shifts filled by bank/agency qualified nursing staff and shifts left unfilled from April 2017 to March 2018 in medicine at The Mid Yorkshire Hospital NHS Trust by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>2,785</td>
<td>5,054</td>
<td>12,522</td>
</tr>
<tr>
<td>Dewsbury and District</td>
<td>633</td>
<td>2,345</td>
<td>3,159</td>
</tr>
<tr>
<td>Hospital</td>
<td>117</td>
<td>244</td>
<td>568</td>
</tr>
<tr>
<td>Total</td>
<td>3,535</td>
<td>7,643</td>
<td>16,249</td>
</tr>
</tbody>
</table>

The trust has identified five medical wards that have among the highest bank/agency usage, because of high vacancies. This includes ward six (4.2% vacancy rate) at Dewsbury.

The trust states that they have a comprehensive recruitment programme, which includes graduate, return to practice and return to the NHS and international recruitment. The trust is focusing on retention of staff and has deployed several initiatives which include career cafes and internal transfer scheme, platinum retention plan, and graduate nurse programme.

Six monthly staffing reviews ensure the workforce meets the demands of the service and allows the wards to consider new workforce models including assistant practitioners, nursing associates and pharmacy technicians.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Doctors told us there was a shortage of junior doctor cover and that there were always gaps in the rotas. These were sometimes filled with locums but they were often moved off their base ward to cover other areas. They sometimes had to carry and respond to two bleeps. Both nurses and doctors told us that the shortage of junior doctors often resulted in a delay in discharging patients.

Although there was a process for medical staff to report sickness / absence, the doctors left shorthanded felt that cover was not sought for them as a matter of course, but they had to chase cover or support themselves. One doctor told us the office had told them to go to another ward to ask for the doctor there to come and help them.
Despite the issues with unfilled shifts the junior doctors said they were well supported by the registrars and consultants, and still had the opportunity to attend their training. Staff told us consultant ward rounds happened every weekday (ward 10).

The trust has reported their staffing numbers below as at March 2018 for medicine:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at March 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mid Yorkshire NHS Trust</td>
<td>276.7</td>
<td>257.4</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 12.6% in medicine, compared to the 9% trust target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 5.9% in medicine, compared to the 12% trust target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 1.1% in medicine, compared to the 4.8% trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

The below table shows total shifts filled by bank/locum medical staff from April 2017 to March 2018 in medicine at The Mid Yorkshire Hospital NHS Trust:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by locum staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td>4,537</td>
<td>16,353</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

The trust supplied information about their fill rates for junior doctors from 12 March to 30 June 2018 across all sites.

<table>
<thead>
<tr>
<th></th>
<th>Filled</th>
<th>Unfilled</th>
<th>Filled %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-18</td>
<td>506</td>
<td>44</td>
<td>92%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>645</td>
<td>68</td>
<td>90%</td>
</tr>
<tr>
<td>May-18</td>
<td>656</td>
<td>108</td>
<td>86%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>566</td>
<td>92</td>
<td>86%</td>
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**Staffing skill mix**
In January 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

**Staffing skill mix for the 210 whole time equivalent staff working in medicine at The Mid Yorkshire Hospitals NHS Trust**

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<th>This Trust</th>
<th>England average</th>
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<tr>
<td>Consultant</td>
<td>50%</td>
<td>43%</td>
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<tr>
<td>Middle career^</td>
<td>5%</td>
<td>6%</td>
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<tr>
<td>Registrar group~</td>
<td>23%</td>
<td>29%</td>
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<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</td>
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^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics - January 2018)

**Records**

Staff kept appropriate records of patients’ care and treatment. Patient records were a mixture of paper based and electronic records. Staff completed nutritional risk assessments, pain assessment and dementia screening on the electronic records system. Other assessments such as patient handling, falls and pressure damage risk assessments were recorded in paper format. Care plans were added to patient records when indicated. For example, there was a catheter care plan, a dementia pathway and a nutrition and hydration care plan. Some paper records where kept at the patient’s bedside. These included intentional rounding charts, food and fluid charts and fluid balance charts.

On most wards paper records were stored in unlocked trolleys; however, these were stored in areas supervised by staff near to the nurse’s station. On ward 6 we saw that notes were stored behind the nurses’ station and were stored vertically so names were not on display.

We looked at sample of 14 patient records which included paper and electronic records. These were completed to a good standard, with few omissions. We found that care plans and risk assessments were completed appropriately. There was evidence of patient involvement care decision making and of multi-disciplinary involvement in care planning and treatment. Hand written entries were legible and signed. There was some conflicting information in one set of records regarding discussion of DNACPR with a patient who lacked mental capacity but it appeared discussion had taken place. The other four records, where a DNACPR was in place, were completed to a good standard. The two sets of records we reviewed for medical patients outlying on a surgical ward showed that risk assessments had been updated and records showed that patients had been reviewed daily by the medical team.
The electronic patient system was used to flag specific patient information, for example, a flag was used for patients living with dementia or those patients with a learning disability. A ‘VIP’ sticker was placed on medical notes of patients with a learning disability and a ‘forget me not’ sticker for patients with dementia.

**Medicines**

Medicines were stored securely with access restricted to authorised staff members. Medicines rooms were tidy and well organised. A centrally monitored system was in place to ensure that medicines were stored at the correct temperature. Medicines and equipment required in emergencies were appropriately stored and checked daily to ensure they were fit for use. However, we found on wards 10, 6, 6b and 15 that intravenous fluids containing potassium were not stored separately from other intravenous fluids. Intravenous fluids on ward 10 were found in unlocked storage which the trust rectified immediately when it was brought to their attention.

Controlled drugs were ordered appropriately. Records checks for stock medicines were completed each day and on all wards, we visited these were correct.

Pharmacy assistants topped up ward stock medicines, however, we found there was no system in place to regularly date check medicines, and out of date medicines and intravenous fluids were found on two of the wards we visited. As soon as the issue was brought staff’s attention they took remedial action and a stock check process and checklist was immediately introduced to be undertaken by nursing staff.

Medicines policies and procedures were available on the trust intranet and links were available to guidelines and reference sources. The trust had a self-administration policy and staff could describe how they would use this policy. However, we found two patients were self—administering medicines without having a risk assessment in place in line with policy.

We found that three people on one ward were receiving their medicines via a naso-gastric feeding tube, however these medicines were prescribed orally or by more than one route on the medicine administration record. No assessment had been documented to show that which route each medicine should be administered by or that they were appropriate for administration via the naso-gastric tube. One capsule for inhalation was prescribed to be taken orally.

When people were prescribed antibiotics there was clear information on indication and review dates.

Some patients were sent to the discharge lounge prior to leaving the hospital. The nurse described the process for administering doses of medicines due during this time, however, we saw one person had missed a dose of medication and another had medication administered two hours after the prescribed administration time.

Medicines reconciliation was completed by ward based pharmacists and pharmacy technicians, we looked at six medicine charts on ward 6 and saw that this was completed within 24-48 hours. Trust targets for medicine reconciliation had not been achieved but were improving. The pharmacist reviewed this information daily and then prioritised patients.

We observed staff on medicine rounds wearing red (do not disturb) aprons this is to reduce the number of distractions and potential for making mistakes.

**Incidents**

Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust governance arrangements. Staff we spoke with knew how to report incidents involving medicines. Significant incidents were discussed and appropriate actions taken in response to concerns.
Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them. Feedback and learning from incidents was cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

The patient safety panel reviewed lessons learnt from serious incident investigations, pressure ulcers and falls. Once identified these were shared with staff via a two weekly patient safety bulletin. The ward manager on 6b told us they had purchased ‘repose wedges’ because of investigation into the cause of pressure ulcers, which had identified a theme with incidence of heel blisters for patients who had fractured their neck of femur and had undergone surgery.

Staff told us information about incidents was also shared at the safety brief which occurred at nurse handover at 8am and 8pm. We saw there was a ‘message of the month’ displayed on the wall for staff on ward 6.

At the inspection in 2017 the division had a backlog of 300 unresolved incidents. The leadership team confirmed that this had now been resolved.

Most of the staff we spoke to knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients. Ward managers were aware of the DoC and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty. DoC was incorporated into the incident reporting system.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for medicine.

(Source: NHS Improvement - STEIS (May 2017 – April 2018))
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 18 (64% of total incidents).
- Pressure ulcer meeting SI criteria with six (21% of total incidents).
- All other categories with one (4% of total incidents).
- Treatment delay meeting SI criteria with one (4% of total incidents).
- VTE meeting SI criteria with one (4% of total incidents).
- Medication incident meeting SI criteria with one (4% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 83 new pressure ulcers, 51 falls with harm and 33 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Mid Yorkshire Hospitals NHS Trust

1
Total Pressure ulcers
(83)

2
Total Falls
(51)

3
Total CUTIs
(33)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: Safety thermometer)

We saw that harm free care information was displayed on ward notice boards, visible to staff, patients and visitors.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We reviewed a random selection of five policies including the falls policy, the safeguarding adults’ policy and the guidelines for the recognition and management of sepsis. All were within their review date.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible
evidence and in line with national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

There was a process in place to ensure that clinical practice was in line with the service NICE guidance. Clinical leads carried out a gap analysis and identified actions required to address any gaps.

The care of the elderly team had designed a new patient assessment document which followed the acute care of the elderly pathway and was based on the Royal College of Physicians guidance. The document was going through the trust governance processes prior to rolling out.

The service regularly reviewed the effectiveness of care and treatment through local and national audit. We saw that following audit, there were recommendations and actions for improvement, which included allocation of lead responsibility, completion dates and evidence to demonstrate that actions had been completed. We saw in the notes of the divisional governance meetings that there were some backlogs in provision of evidence for action plans and these were being chased up.

Medical staff told they were working on a number of new pathways for ambulatory care to increase the scope and guidance for the service at DDH.

**Nutrition and hydration**

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Patients were screened on admission and then weekly using the Malnutrition Universal Screening Tool (MUST). Food charts were completed for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic service. There was a divisional nutritional and hydration group which focused on improvements in this area.

Red jugs and red trays were in use to indicate to staff which patients needed assistance with their meals. We observed that protected meal times were in place and saw patients being supported to eat and drink. We saw that drinks were readily available and were in easy reach of patients.

Wards we visited had a nutrition board which identified, for staff, if patients had specific dietary needs such as a soft diet, pureed or thickened fluids, was nil by mouth or if they required assistance with eating / drinking. The nutrition board was updated at the end of each shift.

Food menus were on a 14-day cycle to provide variety for patients. Ethnic meals could be provided and the menus were available in six different languages on request.

Patients we spoke with on ward 10 felt that food was generally good and staff encouraged them to eat and drink. They told us staff made sure drinks were always available. We saw domestic staff helping patients with food choices and understanding the menu.

Ward 6 staff told us they had volunteers who assisted with patients’ mealtimes.

**Pain relief**

The service managed pain relief well. Patients we spoke with told us staff managed their pain well and we observed that staff checked with patients that pain relief given had been effective. Staff used a pain-scoring tool, from one to 10, to assess a patient’s level of pain. The pain score was recorded on the electronic clinical record system. Pain relief was provided as prescribed and staff would request additional pain relief from medical staff, if required.

We found that patients were asked about their comfort/ pain, each time their observations were carried out.
Patient outcomes

The service participated in relevant quality improvement initiatives, including local and national clinical audits. Local audits included infection control and hand hygiene audits, falls, pressure ulcer, fluid balance and nutrition audits which were carried out monthly or bi-monthly. Ward managers told us that the trust had recently introduced ‘heatmaps’ which enabled them to view data about patient outcomes and ward performance. The managers told us the performance team had provided retrospective data for them so that they could see their performance over the last nine months.

The trust had been identified as an outlier for acute and unspecified renal failure, fluid and electrolyte disorders, septicaemia (not in labour) and acute cerebrovascular disease. Action plans were in place to improve these areas.

The divisional leaders told us that their Hospital Standard Mortality Ration (HSMR) had improved since the acute hospital reconfiguration.

The trust had mixed results from national audits. There were some positive outcomes in the Sentinel Stroke National Audit programme with the trust achieving grade B in latest audit which was an improvement from the previous audit. In the Heart Failure Audit results for Dewsbury District Hospital were worse than the England and Wales average for inpatient metrics and better than England and Wales average in seven of the nine discharge measures. There were mixed results in the National Diabetes Inpatient Audit and the results of the National Audit of Inpatient Falls were poor. The falls work stream discussed the results of the national inpatient falls audit and had put action plans in place to improve results.

Relative risk of readmission

Trust level

From January 2017 to December 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.
Non-Elective Admissions – Trust Level

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Dewsbury and District Hospital

From January 2017 to December 2017, patients at Dewsbury & District Hospital had a higher than expected risk of readmission for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Dewsbury and District Hospital

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.
Non-Elective Admissions - Dewsbury and District Hospital

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Sentinel Stroke National Audit Programme (SSNAP)

The Mid Yorkshire NHS Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, April 2017 to July 2017, which was an improvement from the previous audit, December 2016 to March 2017, where the hospital achieved grade C.

The combined total key indicator level in the overall scores has seen an improvement in performance from grade C to grade B in the latest audit. Data below is for the trust. Dewsbury District Hospital does not provide acute stroke care but does provide rehabilitation for stroke patients.

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<tr>
<th>Overall Scores</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
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Best A  D  C  D  E  Worst N/A No assessment
### Patient centred performance

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<th>Domain 2: Stroke unit</th>
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<th>Jan-Mar 16</th>
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### Team centred performance

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<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
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</table>
- Domain 3: Thrombolysis has seen an improvement from grade C to grade B in the latest audit for both patient and team centred performance.

- Domain 6: Physiotherapy has seen a decline in performance from grade B to grade C in the latest audit for both patient and team centred performance.

- Domain 7: Speech and language therapy has seen a decline in performance from grade D to grade E in the latest audit for patient centred performance.

- Domain 8: Multi-disciplinary team working has seen an improvement in performance from grade E to grade D for both patient and team centred performance.

(Source: Royal College of Physicians London, SSNAP audit)

Heart Failure Audit

In-hospital Care Scores

Results for DDH in the 2016 Heart Failure Audit were worse than the England and Wales average for all four standards relating to in-hospital care.
Discharge Scores

Results for DDH were better than the England and Wales average for seven of the nine standards relating to discharge and worse for the remaining two measures.

(Source: NICOR - Heart Failure Audit (April 2015 – March 2016))

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 28 in-patients with diabetes at DDH. 85.3% of patients at DDH with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 3.

Dewsbury and District Hospital:

- On average, 2.68 diabetes specialist nursing hours per week were spent with each patient in 2017, which places this site in quartile 4 and is the same quartile as in the 2016 audit.
- On average 1.34 consultant hours per week were spent with each patient in 2017, which places this site in quartile 4 and is the same quartile as in the 2016 audit.

(NaDIA 2017 staffing levels were collected as whole-time equivalents (WTE) for the first time, whereas previously NaDIA collected staffing in hours. Cautious interpretation is therefore advised when comparing 2017 results against previous years.)
• 96.4% of patients with diabetes had been admitted to hospital as an emergency, which places this site in quartile 4, compared to quartile 3 in the 2016 audit.

• 3.6% of patients with diabetes were admitted with active foot disease in 2017, which places this site in quartile and is the same quartile as in the 2016 audit.

• 0% of patients with diabetes received a diabetic foot risk assessment within 24 hours of admission, which places this site in quartile 1, compared with quartile 4 in the 2016 audit.

• 0% of patients received a diabetic foot risk assessment at some point during their hospital stay, which places this site in quartile 2, compared with quartile 4 in the 2016 audit.

(Changes to the routing in the NaDIA 2017 Bedside Audit form means that only in-patients admitted with active foot disease can be assessed for this measure. Historic results have been updated using the same method.)

• There was no data concerning when the use of insulin infusions had not been appropriate. 0% of patients had been on an insulin infusion in the last seven days, which places this site in quartile 1, compared with quartile 2 in the 2016 audit.

• 21.4% of patients with diabetes were visited by a member of the diabetes team, which places this site in quartile 1, compared with quartile 2 in the 2016 audit.

• 0% of patients with diabetes admitted with active foot disease were seen by the multi-disciplinary diabetic foot team (MDFT) with 24 hours, which places this site in quartile 1 and is the same quartile as in the 2016 audit.

• 40% of patients with diabetes experienced one or more medication error, which places this site in quartile 4, compared to quartile 2 in the 2016 audit.

• 26.7% of patients with diabetes experienced at least one glucose management error, which places this site in quartile 4, compared with quartile 2 in the 2016 audit.

• Of the patients on insulin, 33.3% experienced one or more insult (prescription or glucose management) error, which places this site in quartile 4, compared with quartile 3 in the 2016 audit.

• 3.8% of patients with diabetes experienced one or more severe hypoglycaemic episode (<3.0mmol/L), which places this site in quartile 1, compared with quartile 4 in the 2016 audit.

• 53.1% of patients with diabetes reported that the timing of their meals was always or almost always suitable, which places this site in quartile 1, compared with quartile 3 in the 2016 audit.

• 70.9% of patients with diabetes reported that all or most of the staff caring for them were aware that they had diabetes, which places this site in quartile 1, compared with quartile 4 in the 2016 audit.

• 43% of patients with diabetes reported that all or most of the staff looking after them had enough knowledge of their diabetes to meet their needs while in hospital, which places this site in quartile 1, compared with quartile 2 in the 2016 audit.

(Source: National Diabetes Inpatient Audit 2017)
Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 25.1% of nSTEMI patients at DDH were admitted to a cardiac unit or ward compared to the England average of 55.8%.

94.3% of nSTEMI patients at DDH were seen by a cardiologist or member of the team compared to an England average of 96.2%.

The proportion of nSTEMI patients who were referred for or had angiography was 67.5% at DDH compared to an England average of 83.6%.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>282</td>
<td>282</td>
<td>361</td>
</tr>
<tr>
<td></td>
<td>97.6%</td>
<td>39.7%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>175</td>
<td>175</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>94.3%</td>
<td>25.1%</td>
<td>67.5%</td>
</tr>
<tr>
<td>England: overall</td>
<td>47,039</td>
<td>47,039</td>
<td>39,082</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 87.9%, which did not meet the audit minimum standard of 90%. The 2016 figure was 1.8%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.6%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 73.5%. This is better than expected and shows good practice. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 76.3%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust in 2016 was 35.4%. This is within the expected range. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit 2017)
National Audit of Inpatient Falls

The Mid Yorkshire Trust participated in the 2017 National Audit of Inpatient Falls and the crude proportion of patients who had a vision assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 30%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 21%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 78%. This did not meet the national aspirational standard of 100%.

(Source: National Audit of Inpatient Falls 2017)

Competent staff

Staff we spoke with told us they received annual appraisal with their line manager and said they found it useful. Ward managers were aware of the ward compliance with appraisals and had plans in place to meet with those staff whose appraisals were outstanding. At the time of the inspection compliance rates were high on most wards. Wards 6, 6b, 10 and 15 had appraisal compliance rates of 94%, 89%, 80% and 88% respectively. Only ward 10 was below the trust target of 85%.

Staff were encouraged to develop and were able to attend additional training if it fit with their role. Newly qualified nurses were given a preceptorship programme and were supported by a mentor. Nurses we spoke with had received a full day induction and two weeks of training. They had received additional training for taking bloods/cannulation and intravenous drugs.

Pharmacy staff also told us they received regular 1-1s and were supported with development to do courses such as; non-medical prescribing and diplomas.

Junior doctors told us they had a good induction when they joined the trust. Those we spoke with could attend their training days although they were aware this sometimes left medical staffing short on the wards.

Staff on wards supported student nurses on clinical placements. Students we spoke with said they felt that their induction had been very thorough and they were well supported and supervised doing tasks such as medications, dressings, toileting and feeding. Students had a ward based mentor and clinical practice facilitators visited them on the ward during their placement. Students reported that they were never asked to do anything beyond their competence.

Patients who presented with higher risks of harm to themselves or others were often observed by unregistered staff or security staff. Mental health training was not mandatory for nursing staff although some ad-hoc training was available.

Appraisal rates

Information provided by the trust showed that the overall appraisal rates for staff working in medical care services on 30 June 2018 were 85% which met the trust target of 85%.

<table>
<thead>
<tr>
<th>Appraisal compliance</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand total</th>
<th>% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisals</td>
<td>209</td>
<td>1232</td>
<td>1441</td>
<td>85%</td>
</tr>
</tbody>
</table>

(Source: Additional Data Request ALL2)
Multidisciplinary working

Staff with specialist skills and knowledge worked well together to benefit patients. Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

The Rapid Elderly Acute Care Team (REACT) were based on ward 6 and were a multidisciplinary team of medical staff, specialist nurses, healthcare assistants, therapists and social care workers. Staff said they worked well together as a team to achieve the best outcome for patients.

Staff spoke highly of the REACT team and their role. Staff valued the part each member of the ward team played in caring for patients and the support given to the whole team and effective running of the ward.

We saw good examples of MDT working. Clinical and non-clinical staff attended twice daily safety huddles to share information about patient risk. Safety huddles on ward 6 included the whole ward team including the housekeeper and domestic staff, so all staff knew which patients were at risk of falling or had other patient safety risks. Wards held multidisciplinary board rounds Monday to Friday. We observed a board round on ward 6, which was attended by medical staff, allied health professionals, ward staff and members of the REACT team. All patients on the ward were discussed in detail including safety risks, social situation and discharge planning. Actions were identified and noted which required completion before the patient could be safely discharged home. There were weekly multi-disciplinary meetings held on ward 10 to discuss the progress and plans for the stroke and neuro-rehabilitation patients and daily consultant ward rounds were attended by members of the multi-disciplinary team.

Referral pathways were in place for referral to the speech and language therapist, podiatrist and dietician. Pharmacists and pharmacy technicians supported wards.

Specialist nurses were available to offer support, advice and training to staff in a number of specialist areas. These included tissue viability, dementia, diabetes, falls and learning disability.

Staff from the psychiatric liaison team and the medical wards valued each other’s input. They told us that the teams worked well together to meet patients’ physical and mental health needs. Staff told us the psychiatric liaison team provided good guidance to ward staff to ensure that patient’s mental health needs and risks were addressed. However, in the records we reviewed, we did not find documented evidence of this.

Seven-day services

Therapy staff in the REACT team provided a seven-day service to support timely discharge and therapy input was available on ward 10 for stroke and neuro-rehabilitation patients. Otherwise therapy was provided Monday to Friday with on-call provision for urgent chest physio. Therapy team leaders told us that seven-day working was gradually being rolled out in therapy teams and there was access to an on-call physiotherapist for chest problems.

Ward staff could access specialised support from the psychiatric liaison team, which included registered mental health nurses and psychiatrists. The psychiatric liaison service worked 24 hours a day, 7 days a week with all adult patients. Staff had access to other specialist staff, such as psychologists.

The nearby mental health trust had an adult crisis team that operated 24 hours a day, seven days a week and acted as gatekeeper to mental health beds.
Pharmaceutical services were also available 7 days per week during the day, with on-call provision for emergency support/advice out of hours.

Health promotion

We saw lots of health promotion information on the wards and around the hospital. For example, the information included; healthy eating, staying healthy stopping smoking, local alcohol services, carers support and falls prevention. There were a range of Age UK leaflets available and a dementia awareness information boards.

The learning disability lead nurse carried a supply of annual health check leaflets and gave these to patients with a learning disability and their carers to encourage them to attend.

The REACT team had developed information leaflets regarding delirium, following their experiences with a patients and relatives who hadn’t understood the impact of infection and as a cause of delirium.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The MCA allows restraint and restrictions to be used but only if they are in a person’s best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS).

Patients were asked their consent to share information regarding their care with others involved in their care. This was recorded in the nursing records. Consent to treatment leaflets for patients were on display on some wards we visited.

All patients over 64 years of age or those with concern about memory were screened for dementia using the abbreviated mental test score (AMTS).

Staff we spoke with understood the basic principles of the MCA and DoLS. They told us that if they needed to complete a DoLS application they could access help from the safeguarding team. Some staff had a good understanding of mental capacity and best interest decisions but were unclear what constituted deprivation of liberty, when this would apply and how this should be documented or a formal application made.

We saw limited examples of mental capacity assessments or decisions made in line with the principles of the MCA. Where patients lacked capacity, recording that the decision was in the patient’s best interests was not consistent.

We saw that a patient on ward 6 had suffered an episode of delirium which involved security and assisting with keeping the patient safe and on the ward. There was no evidence in the patient’s notes regarding MCA assessment or best interest decision making. However, the psychiatric liaison team did carry out a mental capacity assessment later during the patient’s stay.

This meant that while nursing staff had some understanding of the principles of the MCA and the DoLS, we could not be assured that their understanding was sufficient to always ensure their practice upheld them.

The trust had carried out an audit of the completion of consent Form 4 which was for adults who potentially lack the capacity to consent to investigation or treatment. The audit had identified some
areas of good practice and areas for improvement with an action plan. The audit would be repeated in 2019 to see if improvements had been made.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff were required to complete training in MCA and the DoLS. Information provided by the trust on 30 June 2018 showed that the overall compliance for staff within the division of medicine was 99% for level 1 training, which exceeded the trust target of 95%. Compliance with level 2 training was 80% and for level 3 training it was 55%, which did not meet the trust target of 85%.

The trust informed us that the reason for the level 3 training compliance being low was that initial training took place for a large number of staff in 2015 and as staff were required to complete the training every three years, a number of staff had fallen out of compliance. However, further masterclasses were planned and the trust was looking at alternative ways to provide this specialist training.

*(Source: Additional data request MED 14)*

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We spoke with 15 patients and relatives throughout the inspection. Patients and relatives told us that they had been treated kindly and that staff were polite and respectful.

All patients we spoke with were happy with the standard of care they received. They had drinks and call bells located within easy reach. Patients told us they felt safe.

We overheard discussions between staff and patients and these were carried out in a compassionate and supportive way. Staff gave reassurance and provided information at a pace appropriate for the patient. We observed patients’ privacy and dignity were maintained when staff delivered care.

We spoke to 5 patients on ward 10 who told us that staff were very caring and had a good attitude. Most of the patients felt the staff explained things well to them and included their relatives where appropriate. Patients told us they felt the care was of good quality and that they felt safe on the ward. However, a patient on ward 10 told us they had been incontinent because they had to wait too long for staff to be able to see to their toileting needs. Two patients on ward 10 said that there wasn’t always enough staff on duty, which meant they had to wait for their needs to be met. They said staff were caring but were run ragged at times.

We observed the housekeeper on ward 6 was particularly kind and encouraging with a patient, taking the time to explain all mealtime choices to support their nutritional needs and personal preferences. However, we did observe one occasion on ward 6 when a patient’s dignity was not upheld by a member of staff shouting across the ward corridor for help with a patient who had been incontinent.

On ward 6b (8) a patient and their relative stated that “all the staff on this ward have been lovely and they can’t fault the care”. They had been involved in planning for discharge and were clear about discharge plans and expected date of discharge.

On ward 15 we observed a weekly tea party where family and friends are invited to have tea and cakes with their relatives. The ward staff had gone to a lot of effort to set up a table with a traditional cloth and provide a trolley with cakes on a cake stand. There was a lovely atmosphere, very relaxed families sat in small groups chatting. We spoke with three relatives who were very happy with the care provided here. They said there were plenty of staff and the ward is very active.
Staff are always prompting patients to have a drink and patients and relatives are kept well informed. They loved the tea party idea to bring a bit of normality for patients and liked that there was access to tea and coffee they could go and get one for their relative.

The trust was promoting a nurse handover tool which encouraged staff to handover patients ‘at the bedside’ to preserve patient confidentiality and dignity. We saw signage displayed on the doors to the bedded bays to remind staff of this.

From March 2017 to February 2018, the friends and family test response rate for medicine at the trust was 24%, which was about the same as the England average of 25%. The response rate for DDH’s was 26% (based on 1,881 responses).

A breakdown of the friends and family test performance by site and for medical wards at the trust with total responses over 100 is below. The monthly figures show recommendation percentage and not response rates.

**Friends and family Test – Response rate between March 2017 and February 2018 by site and ward**

**Dewsbury and District Hospital:**

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<tbody>
<tr>
<td>(SSU) Ward 6</td>
<td>375</td>
<td>61%</td>
<td>98%</td>
<td>98%</td>
<td>94%</td>
<td>88%</td>
<td>94%</td>
<td>96%</td>
<td>83%</td>
<td>100%</td>
<td>97%</td>
<td>80%</td>
<td>94%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>(SSU) Ward 8</td>
<td>311</td>
<td>53%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>98%</td>
<td>92%</td>
<td>100%</td>
<td>93%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>(MAU) Ward 10</td>
<td>425</td>
<td>87%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>93%</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ward 11</td>
<td>260</td>
<td>25%</td>
<td>96%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
<td>100%</td>
<td></td>
<td>92%</td>
<td>98%</td>
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<td></td>
<td></td>
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<tr>
<td>Ward 12</td>
<td>142</td>
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<td></td>
<td></td>
<td>92%</td>
<td>98%</td>
<td>100%</td>
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</table>

Highest score to Lowest score

<table>
<thead>
<tr>
<th>Key</th>
<th>100%</th>
<th>50%</th>
<th>0%</th>
</tr>
</thead>
</table>

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

Medical assessment unit (MAU) had the lowest response rate with 25%, whilst the short stay unit (SSU) had the highest response rate with 87%.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. One patient told us how a consultant and nurse had assessed their mental / emotional state and had ensured specialist support was provided. This had helped the patient greatly with her rehabilitation and recovery.

Relatives of patients living with dementia were offered information on voluntary organisations, which could provide them with support and advice. Information about several different charities and voluntary organisations was displayed on notice boards in ward areas,

Quiet rooms were available for relatives if they needed to speak to staff confidentially or if they were feeling distressed and needed somewhere quiet to sit.

Where appropriate, staff could also make referrals to the psychiatric liaison team, which was available 24 hours a day.
Spiritual and pastoral support was available to patients, relatives, carers and staff. There was a multi-faith centre on site with a chapel and a prayer room. Chaplains were available to provide services for different faiths in the chapel or at the patient’s bedside.

**Understanding and involvement of patients and those close to them**

Patients and relatives, we spoke with told us they were kept up to date with what was happening and were involved in decisions about their care. Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions.

We saw evidence in patient records that patients and their relatives had been involved in making decisions about their care and treatment. Relatives told us they were kept well-informed and they involved in care planning and discharge arrangements.

Wards displayed photos and designations of ward staff so patients and visitors understood who they were.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The division had realigned their services as part of the acute hospital reconfiguration. This involved the centralisation of acute in-patient services at Pinderfields Hospital. As part of the reconfiguration they had opened two acute frailty assessment units (one at Pinderfields and one at DDH) which accepted direct referrals. Pathways to DDH and Pontefract Hospital had been created, and these hospitals were now designated step-down facilities.

The ambulatory care service was staffed by a dedicated team of consultants, doctors, advanced nurse practitioners (ANPs) and healthcare assistants who worked at the Pinderfields and Dewsbury sites. The service enabled non-critical patients to be seen quickly and relived pressure on the emergency department. Patients could be referred directly to the unit by their GP.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, the trust had a learning disability lead nurse and VIP champions on the wards.

**Average length of stay**

**Trust Level**

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 7.8 days, which is higher than the England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.

**Elective Average Length of Stay – Trust Level**
Note: Top three specialties for specific trust based on count of activity.

For medical non-elective patients, the average length of stay was 6.5 days, which is similar to the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Dewsbury & District Hospital

From February 2017 to January 2018 the average length of stay for medical elective patients at Dewsbury & District Hospital was 6.2 days, which is higher than the England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in respiratory medicine is higher than the England average.

Elective Average Length of Stay - Dewsbury & District Hospital
For medical non-elective patients, the average length of stay was 6.5 days, which is similar to the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

**Non-Elective Average Length of Stay - Dewsbury & District Hospital**

Note: Top three specialties for specific site based on count of activity.

**Meeting people’s individual needs**

The service took account of patients' individual needs. The trust had a full-time learning disability lead nurse. All patients with a learning disability were flagged on the electronic patient administration system. The lead nurse received a daily report of all flagged patients and visited to offer support and information. Family members or care staff from supported living were encouraged to stay and support the patient in the hospital setting. VIP passports were in use for patients with a learning disability, which included sections about the patient’s health, reasonable adjustments, eating and drinking, communication needs, decision-making and support needed.

There was a specialist lead nurse for dementia for the trust and dementia champions on the wards. Patients with dementia were flagged on the system and were identified to staff at safety huddles, board rounds and handovers. A forget-me-not scheme was in use, we saw these
displayed on the board at the back of patients' beds and in patients notes. On admission, all patients over the age of 75 were screened for dementia.

The hospital aimed to meet the principles of ‘John’s Campaign: for the right to stay with people with dementia in hospital’.

Staff could access translation services through the switchboard. They could book a face to face interpreter or a booked call in the patient’s language. They could also book a face to face British Sign Language interpreter.

Posters were displayed in over 10 different languages which gave patients information on how to get more information in their own language should they need it. We saw ‘tell us what you think’ posters and leaflets were available in several languages.

To meet the needs of patients with sensory loss, patient information was available in different formats such as braille. This could be requested via the patient advice and liaison service. The trust website had the facility to enable patients to increase the font size of the text, convert the text into different languages, read the page content aloud and download patient information leaflets as audio files.

Patients with mental health needs were referred to the psychiatric liaison service and seen by trained mental health staff. The psychiatric liaison service worked 24 hours a day, 7 days a week.

We saw that patients had buzzers within reach, they were dressed in day clothes and had lockable storage at their bedside. Wards had dayrooms where patients could watch videos and they had radio’s in their bays but there were no individual TVs. Patients on ward 15 were encouraged to take part in a weekly tea party to provide the opportunity for interaction with families and other patients.

We observed a HCA providing care to a patient on ward 10, considering their cultural beliefs and individual preferences. A hairdressing service was available for patients on ward 10.

**Access and flow**

At the inspection in May 2017 we were concerned about the use of extra capacity beds on medical wards. At this inspection we found no additional capacity beds on the wards we visited. The leadership team told us that all extra capacity beds had been closed at the end of April 2018. The trust had worked with the wider system to improve admission and discharge planning. This included working with local authorities and clinical commissioning groups.

At the last inspection we also identified a high number of out of hours bed moves. At this inspection we were also concerned about the number of bed moves at night (see figures below).

There were a small number of medical patients outlying on surgical wards at the time of our visit. We found these patients had been regularly reviewed by medical staff.

The Rapid Elderly Acute Care Team (REACT) was based on ward 9 at DDH. The team’s role was to facilitate the timely and safe discharge of patients over 80 years of age and those aged over 65 years living in care homes. The team also fast-tracked discharge for patients at their end of life who wanted to die at home. The service carried out weekly audits to measure effectiveness. Audit results were reviewed by the team leader and business manager to aid service improvement. Staff told us they focused on those patients who could be discharged within 48 to 72 hours.

The discharge team monitored patient discharge status across the division and focused on stranded patients. They liaised with community colleagues and support services to assist patients who were medically fit for discharge. Discharge co-ordinators were based on medical wards to support patients’ safe discharge home. A member of staff told us this had been a recent team as
they had originally been a member of a central discharge team. They felt this was a better way of working as “I can really get to know the patients I am arranging things for and I can be involved in the handover”. The discharge coordinator on ward 6b carried out a monthly audit to look at peak times for discharges and kept records of all transfers in and out to inform the work of the ward and help with planning.

Ward 10 was the stroke and neuro-rehabilitation unit and took rehabilitation patients from Pinderfields Hospital and other regional hospitals. Staff told us the patients must have rehabilitation potential to be accepted and there was a waiting list for patients to be admitted.

There was a discharge hub based at Pinderfields Hospital which had a lounge area at DDH open Monday to Friday 10am to 6pm. The discharge lounge could accommodate 10 patients, it had eight chairs and two single bed rooms. Staff from the discharge lounge visited the wards daily to identify patients who were able to use their facility. Patients were not identified to discharge lounge staff prior to the day of discharge.

Staff generally felt that transfers from Pinderfields to Dewsbury were appropriate but commented that it was not always easy to get patients back to Pinderfields if they became unwell. Ambulatory care staff also commented that the wait for transport to Pinderfields could be lengthy if patients needed admission.

Patients were referred to the ambulatory care unit from the A&E department or direct form GPs. Referrals were accepted by doctors and nurses if patients could be assessed and treated under various pathways such as; suspected deep vein thrombosis (DVT). However, there was no triage system or specific suitability criteria in place, this meant that some patients were seen but then needed to be admitted to Pinderfields hospital.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average. In the latest period, March 2018, 85.6% of this group of patients were treated within 18 weeks versus the England average of 88.9%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>93%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>92.3%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>80.4%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.9%</td>
<td>82.9%</td>
</tr>
<tr>
<td>General medicine</td>
<td>61.9%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>60.0%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission

The trust stated that they unable to provide the data requested as their system does not have the functionality to differentiate between moves for clinical and non-clinical reasons.

(Source: Trust Routine Provider Information Request P51)

Patient moving wards at night

The trust stated they are only able to provide comparative data for the last six months, due to a reconfiguration of their acute hospital services.

Data provided by the trust indicates there were 84 ward moves at night at DDH from October 2017 to March 2018. The number of moves per ward ranged from zero to nine per ward per month. Ward 11 (elderly step down) had the most bed moves at night with 27 in the period from October 2017 to March 2018.

(Source: Trust Routine Provider Information Request P52)

Learning from complaints and concerns

Most staff told us that complaints were discussed with them at team meetings or individually if the complaint concerned them.

Ward managers we spoke with were aware of themes and trends from complaints and number of complaints and severity had been included in the heatmap data provided to the ward managers. Complaints were discussed at bi-monthly team meetings or shared with staff in a newsletter.
One ward manager told us about a recent complaint was to do with lack of weekend therapy and how this was being addressed.

**Summary of complaints**

From April 2017 to March 2018 there were 281 complaints about medical care (compared to 1,624 in 2016-2017). The trust took an average of 25 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 working days.

The most common subjects of complaint were:

- Patient care (157 complaints, 56% of total complaints for this core service)
- Admissions and discharges (excluding delayed discharge due to absence of care package) (40 complaints, 14% of total complaints for this core service)
- Staff’s values and behaviours (33 complaints, 12% of total complaints for this core service)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 59 compliments within medicine:

- Dewsbury and District Hospital: 31 compliments
- Pinderfields Hospital: 28 compliments

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

The Division of Medicine was led by a clinical director, a director of operations and two assistant directors of nursing.

We saw effective ward managers. Wards were well organised and appeared calm. Staff spoke highly of their ward managers and said they felt well supported. Ward managers spoke highly of their matron and the senior nurse.

We received good positive feedback about the chief executive, the chief operating officer and the director of nursing and quality. Staff said they were visible, approachable, listened to them and acted on what they said.

Staff gave examples of the chief executive visiting wards to ask staff directly of their opinions about planned changes to services or policies and what the implications for them might be. Staff said the chief executive replied directly to staff if they had written to him with concerns or ideas.

Ward managers said they were clear where the service was heading and this was in the right direction.

Therapy and nursing staff were able to attend a certified leadership training provided by the organisation. Nursing sisters, charge nurses and ward managers could also apply to go through the Royal College of Nursing leadership accreditation scheme. Staff attributed this investment in their leadership development to the new chief executive and the executive team. Ward managers who had undergone this training welcomed this investment in their development.
The matron for the hospital clearly understood the challenges in the service and was acting to make improvements. There was evidence of improvements since the matron’s appointment and their work was clearly focused on improving staff professionalism, and patient care and experience. The matron was reported as being supportive, visible and approachable and visited the wards every day.

Staff and students on the wards spoke positively about their managers and leaders and told us they were happy to work there. Managers encouraged staff at all levels to speak up and suggest improvements.

Ward managers told us they had 15hrs a week dedicated time for managerial duties.

However, we found a lack of leadership and ownership regarding the ambulatory care service and the discharge lounge at DDH. This appeared to be compounded by these services being centralised at Pinderfields hospital and staff being assigned to work in these areas on a rota basis. There did not seem to be clear oversight of the physical environment and development of these services on the Dewsbury site.

**Vision and strategy**

The Division of Medicine had a clear vision and strategy. They had recently implemented a new model of care with the acute hospital reconfiguration. Staff we spoke with were aware of this and had been involved in the consultation and planning process.

The trust vision, mission and strategic aims were displayed on notice boards around the medical wards. We saw that some wards had developed and displayed team goals for staff and patients to see. For example, wards gave themselves goals to implement the gold standard framework for end of life patients and to reduce patient harms.

Ward managers and staff were aware of the goals for their areas and how they were being worked towards. Staff in the ambulatory care unit had ideas for how they would like to develop the service at Dewsbury but needed to share these with the senior leadership team.

**Culture**

Staff said the culture had improved since the last inspection and was more open. Staff told us they were encouraged to speak up and would feel confident raising concerns with their manager.

Medical staff described the culture as having a good energy and being open and transparent. They spoke positively about the medical director saying they were welcoming and well-respected.

Staff supported each other well and there was good team work. Teams we spoke with were proud of the services they provided to patients. Staff told us the trust was a great place to work.

We found staff to be friendly, helpful and enthusiastic, with a desire to improve services for patients.

Staff we spoke with were aware of the trust values of caring, improving, respect and high standards which were underpinned with expected behaviours. We saw these displayed in the areas we visited.

The trust had a freedom to speak up guardian. Staff we spoke with were aware of this role and how to contact the guardian if necessary.
Governance

Governance arrangements were in place with clear routes for concerns to be escalated from staff to the senior management team and a clear line of escalation from the divisional team to the trust board via the board committees.

Ward managers attended a quality meeting every Tuesday. The meeting was chaired by a matron or a deputy head of nursing. The meetings were themed on a four-weekly cycle to discuss falls, pressure damage, infection prevention and control and patient experience. The clinical governance lead for the Division of Medicine also attended the meeting. Information from speciality meetings was fed into the divisional governance meetings.

The Division of Medicine held monthly governance meetings which fed into the quality committee. We reviewed the minutes of these meetings and saw that risks, patient safety, incidents, safeguarding and effectiveness were some of the items discussed. Themes and trends were identified and lessons learnt. Matters to escalate to the quality committee were agreed at the end of each meeting.

The trust had a service level agreement with the local mental health trust. This provided assurance that the trust received specialist medical and administrative support to ensure they met their responsibilities and worked within the Mental Health Act and Mental Health Act Code of Practice.

There was a lack of oversight of stock management for medicines on some wards but this was addressed when the trust was made aware of it, during the inspection. There was a lack of ownership of among staff for systems and processes and the environment in the discharge lounge and ambulatory care areas.

Management of risk, issues and performance

The leadership team were aware of their main risks and could explain the actions in place to mitigate their risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and were regularly reviewed.

The divisional leadership team identified nurse staffing, their reliance on locum doctors and activity levels as their three top risks. They were also concerned that the regional reconfiguration of stroke services and the proposed closure of the hyper acute stroke unit at a neighbouring trust posed a risk to their services.

Staff could identify local risks and were clear on how to escalate this risk to their managers. Ward managers had their own local documented risks and could tell us what actions had been taken to reduce those risks.

We found evidence that managers used information to measure performance. There was a comprehensive monthly performance dashboard for the Division of Medicine. The dashboard included performance measures and information about the quality and safety of patient care. Targets were set for each area of performance and the dashboard clearly indicated (using a red/amber/green rating) which targets were met and which were not. The report enabled the senior team to have oversight of any areas where performance was lacking and required improvement and areas in which improvements had been made.

The performance report included data on safe care, staffing, performance indicators and identified issues of data quality. Data was provided in both written and graphical form to enable themes and trends to be easily identified.
Information management

Information management systems were used effectively for patient care and for audit purposes to monitor and improve quality.

Ward managers had access to performance information on individual ward heat maps. Heat maps were available for all medical wards and contained monthly data on staffing, patient safety, infection prevention and control, patient experience and nursing quality governance. The heat map was being further developed to provide additional data to ward managers.

Engagement

The trust held an annual staff awards event to recognise and celebrate excellence. Staff and teams could also be nominated for ‘My Star’ awards. Winners would receive gift vouchers and were presented with a framed certificate. We saw several of these displayed in the areas we visited and staff we spoke with were proud to have won awards or been nominated. A HCA working with the REACT team had won the HCA of the year award for their contribution to the team and improving patient information and pathways.

There was a workforce of 600 volunteers at the trust who were given a certificate to thank them for their support and dedication. Long service was also recognised and rewarded.

The executive team had awarded all staff an additional day off in recognition for their hard work and efforts.

The leadership team met staff regularly at engagement meetings and received feedback from the freedom to speak up guardian. Regular staff forums took place for nursing staff and junior doctors. The leadership team acknowledged that there were some issues affecting morale of the junior doctors and hoped the forums would help resolve some of the issues.

Notice boards displayed thank you cards and letters from patients and relatives. We also saw ‘what we are proud of’ information displayed on wards.

There was a patient engagement strategy. Patient experience was discussed every four weeks at the ward manager quality meeting. A patient representative or members of the PALS team were invited to the meeting to contribute to the discussion.

The Rapid Elderly Acute Care Team (REACT) was supported by a project group which included both a patient and carer network representative and local patient representatives.

Wards displayed ‘listening to you boards’ with details of issues patients had raised and what solutions had been put in place. We saw that wards displayed a visitor’s charter which included an explanation of when / why patients no longer needed a hospital bed.

All medical wards participated in the friends and family test. Five additional questions based on the trust patient experience priorities had been added to the inpatient friends and family test cards. Themes and trends from test results and complaints were used improve services to patients.

Staff told us that discharge co-ordinator posts had been allocated to wards in response to patient feedback about discharge processes. TVs, radios and DVDs had been purchased in response to feedback regarding lack of stimulation.

Information board contain information on the NHS inpatient survey in three languages most relevant to the local community.

Staff felt the trust invested in them, a ward manager told us that the trust had sponsored them through their nurse training and they had been supported all the way to promotion to a ward.
manager. Other staff told us they had good job satisfaction and students told us they would be happy to be employed by the trust on the medical wards when they finished their training.

**Learning, continuous improvement and innovation**

Staff were encouraged to undertake a service improvement project as part of the leadership programme. Medical staff told us about quality improvement projects regarding medical handover and antibiotic use. The ward manager on ward 6b told us there was improvement work ongoing around criteria led discharge. Matron told us about the rapid improvement work that been undertaken to improve recruitment timescales. It had originally taken around 80 days to get a job out to advert from a member of staff handing their notice in, this could now be completed in a week.

Staff told us the management team was supportive of personal development.

The division carried out rapid improvement projects to improve services. There was support for staff who wanted to improve services.

Staff were keen to share the innovative work they were involved in. For example, the Rapid Elderly Acute Care Team (REACT) had made a presentation at Royal College of Nursing conference.

The trust had an improvement work stream to reduce patient falls which was led by the falls prevention practitioner. The falls work stream was in collaboration with the improvement academy and commissioners and was underpinned by a comprehensive action plan. From April 2017 to January 2018 the trust achieved a 16% reduction in falls with harms against a target of 10% compared to the previous year.

Safety huddles on ward 6 included the whole ward team including the housekeeper and domestic staff, so all staff knew which patients were at risk of falling or had other patient safety risks.

There were early signs that the acute hospital reconfiguration was improving the Hospital Standard Mortality Ratio (HSMR) for the trust.

Staff were rewarded for innovative work through the staff awards scheme and through the ward accreditation scheme recognising improvements in audit outcomes and reduction in patient harms.
Maternity

Facts and data about this service

The Mid Yorkshire Hospitals NHS Trust provides maternity services over three hospital sites. Following a service re-design in September 2016, all inpatient and obstetric led maternity services were amalgamated on the Pinderfields Hospital site.

Maternity services at Dewsbury and District Hospital include antenatal clinics, an antenatal day unit, and a midwifery-led (standalone) birth centre. The birth centre was opened in September 2016 as part of the reconfiguration of maternity services at the trust.

The Bronte birth centre has four rooms, one of which has a large birthing pool that mothers can use for labour and delivery. The birth centre is in within the grounds of the hospital, with no other inpatient obstetric or neonatal services onsite. The unit therefore supports low risk women who want a birth in a ‘home away from home’ setting. Those considered high risk or who require additional care are transferred to Pinderfields Hospital.

From January 2017 to December 2017 there were 5,925 deliveries at the trust. A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at The Mid Yorkshire Hospitals NHS Trust – Comparison with other trusts in England
A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

### Profile of all deliveries (January 2017 to December 2017)

<table>
<thead>
<tr>
<th></th>
<th>MID YORKSHIRE HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries [n]</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,854</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>71</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mother’s age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>268</td>
<td>4.5%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,774</td>
<td>80.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>748</td>
<td>12.6%</td>
</tr>
<tr>
<td>40+</td>
<td>135</td>
<td>2.3%</td>
</tr>
<tr>
<td>Total</td>
<td>5,825</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics
Notes: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the chart below.

### Number of deliveries at The Mid Yorkshire Hospitals NHS Trust by quarter

![Bar chart showing deliveries by quarter from 2015/16 Q4 to 2017/18 Q3]

Source: HES - Deliveries (January 2017 - December 2017)

From July 2017 to June 2018, there were 6,365 deliveries at the trust. Of these, 307 deliveries were at the Bronte birth centre, Dewsbury and District Hospital.
Is the service safe?

**Mandatory training**

Mandatory training data was not available for staff at this location. The data presented relates to staff within maternity services across the trust.

All attendance at training provided by the service was monitored by the midwifery clinical educator and matrons. Staff were automatically rostered to attend mandatory training. We were told that non-attendance at mandatory training was treated seriously and escalated to the matrons and Interim Head of Midwifery (IHOM), as required.

**Mandatory training completion rates**

The trust set a target of 95% for completion of level 1 (core) mandatory training, and 85% for level 2 (role specific) mandatory training.

**Trust level**

Breakdowns of compliance for mandatory training courses for all applicable staff in maternity services at the trust as of June 2018 were provided.

The table below shows core training course compliance for all staff within the service, against a trust target of 95%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity Awareness</td>
<td>449</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 1</td>
<td>439</td>
<td>450</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety Level 1</td>
<td>430</td>
<td>450</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>422</td>
<td>450</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>387</td>
<td>450</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>377</td>
<td>450</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td><strong>2504</strong></td>
<td><strong>2700</strong></td>
<td><strong>93%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Overall, 93% compliance was achieved for the core mandatory training courses shown above, just below the trust target of 95%.

The trust target was met for three of the six mandatory training courses; a fourth (infection control) fell slightly short of target (94%). Compliance was not achieved against trust target (95%) for information governance (86%) and fire safety (84%) training courses.
The table below shows core training course compliance for applicable (role specific) staff within the service, against a trust target of 85%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management Level 2</td>
<td>266</td>
<td>275</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>398</td>
<td>419</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation Training</td>
<td>358</td>
<td>394</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 2</td>
<td>305</td>
<td>357</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>348</td>
<td>423</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety Level 2</td>
<td>298</td>
<td>395</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td><strong>1994</strong></td>
<td><strong>2285</strong></td>
<td><strong>87%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Overall, 87% compliance was achieved for the role specific mandatory training courses shown above, surpassing the trust target of 85%.

The trust target was met for five of the seven mandatory training courses; a sixth (patient safety) fell slightly short of target (82%). Compliance was not achieved against trust target (85%) for health and safety level 2 training (75%).

Mandatory training for staff working in maternity services should include neonatal and obstetric emergencies training as a minimum (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

Midwives and health care assistants (HCA) attended a one-day Yorkshire Maternity Emergency Training (YMET) obstetric mandatory programme; which included obstetric emergencies, mandatory skills and drills, deteriorating patient, sepsis, and human factors training. Managers expected staff to attend the annual YMET as a priority.

The service provided trust-wide data for the maternity workforce that showed 95% of all applicable staff (356 of 375) had completed YMET training as of the end of June 2018. Data was provided for staff groups, which showed 96% of qualified midwives and nurses, 92% of maternity support workers and assistants had completed the training.

At our previous inspection in May 2017, we found there was not a regular programme of skills and drills at the birth centre. At our recent inspection, all staff we spoke with said they had been involved in regular skills and drills training.

In addition to annual skills and drills (YMET) training, staff told us that regular ad-hoc skills and drills training took place at the birth centre. Previous ad-hoc skills and drills training had included responding to post-partum haemorrhage, cord prolapse, eclampsia, shoulder dystocia, and vaginal breech scenarios.

We reviewed data provided by the trust, which showed 99.5% of qualified midwives and nurses across at trust-level (241 of 242) had completed fetal (CTG) monitoring training.
The trust informed us that they had recently started providing voluntary third and fourth degree tear training to maternity services staff. We reviewed a training agenda and saw the programme began in 2017 and had 24 attendees over the first two courses. A further teaching session was planned for the October 2018. Senior staff told us they expected more attendees over the next 12 months, now that the study days funded by Health Education England had been completed.

The Women’s and children’s group action plan (2017) detailed that neonatal resuscitation training was to be provided to all maternity service staff as mandatory training, with an implementation date of August 2018.

**Safeguarding**

**Safeguarding training completion rates**

**Trust level**

The trust set a target of 95% for completion of level 1 (core) safeguarding mandatory training, and 85% for level 2 and level 3 (role specific) safeguarding mandatory training.

A breakdown of compliance for safeguarding mandatory safeguarding training courses for all applicable staff in maternity services at the trust as of June 2018 was provided.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (L1)</td>
<td>448</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (L2)</td>
<td>183</td>
<td>195</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (L3)</td>
<td>190</td>
<td>205</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (L1)</td>
<td>443</td>
<td>450</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (L2)</td>
<td>351</td>
<td>399</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met completion targets for all five safeguarding training modules for which maternity services staff were eligible.

Midwives received annual safeguarding level three training in line with the intercollegiate guidelines. As of June 2018, records showed 93% of midwives had completed this training against a trust target 85%.

There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children at the trust, based at Pinderfields Hospital. The safeguarding midwife was integrated into the safeguarding team. We reviewed a CQC action plan developed by the service (dated to July 2018) that detailed staff at the location had regular safeguarding supervision sessions with the safeguarding lead midwife.

Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. Staff told us they were happy to contact the safeguarding team/midwife for advice and support if required. Staff also said that there was a local authority domestic violence group that could be accessed for information and advice.
There was a safeguarding integrated care pathway in use across maternity services at the trust that utilised an established vulnerability assessment tool. It provided a contemporaneous record of care, contacts and conversations that the midwife had with the mother and other professionals, with the information transferred to the records of the new baby. ‘Flags’ were used in patient care records and on electronic systems to alert staff to safeguarding concerns.

From April 2018 to March 2018, 296 child safeguarding referrals and 23 adult safeguarding referrals were made by maternity services staff at the trust.

The trust had a Female Genital Mutilation (FGM) policy in place (July 2017). The policy required practitioners to complete an incident form for every case of FGM or suspected FGM that was identified during the delivery of healthcare within the trust. The Safeguarding Team are alerted to the incident report via the incident reporting system. Training on FGM was delivered through the trust safeguarding training.

Access to the birth centre was via an intercom system. There were surveillance cameras in place that enabled staff to monitor people visiting and leaving these areas and helped keep the women, their babies and staff safe.

**Cleanliness, infection control and hygiene**

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks with hand washing technique signs. Hand gels were located at entrances with signs encouraging their use, and throughout clinical areas.

We saw staff washing their hands and using hand gel between patients, as appropriate. All staff we met adhered to arms bare below elbows guidance.

Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

Clinical areas were visually clean, and the cleaning schedules we reviewed were fully completed. We saw infection prevention and control flowcharts displayed that showed cleaning procedures for different environments and equipment. Infection prevention and control information posters and leaflets were displayed in the areas visited.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services at the trust in the last 12 months. Single rooms were available for the isolation of patients, if needed.

The service conducted monthly infection, prevention and control audits. June 2018 data showed overall compliance (across 12 individual measures) was 97% at the location.

In the 2017 CQC maternity survey, the trust scored 9.0 out of a possible 10 for the cleanliness of rooms and wards; this was similar to the England average.

**Environment and equipment**

Maternity services at Dewsbury and District Hospital included antenatal clinics, an antenatal day unit, and a midwifery-led (standalone) birth centre.

The Bronte birth centre had four rooms, one of which had a large birthing pool that mothers could use for labour and delivery. There was also a postnatal room with a double bed; and partners could stay with the woman and baby following delivery.
Staff confirmed they had sufficient equipment to meet patient needs and appropriate training to use it.

The clinical equipment that we checked was found to have in date electrical testing labels.

We reviewed a variety of emergency and essential equipment across the maternity service. This included adult resuscitation trollies, emergency drug boxes, resuscitaires, emergency trolley box, sepsis box, post-partum haemorrhage (PPH) eclampsia and cord prolapse emergency trollies. During the inspection, we found all checks on emergency and essential equipment were complete.

There was adequate equipment in the birth centre to meet patients’ needs. This included a variety of equipment for women to use in labour; for example, birthing balls, birthing stools, birthing couches, and TENS machines.

Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation across clinical areas. The utility and stock rooms we inspected were clean and well organised.

Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use. We found that labels were available and used appropriately.

Assessing and responding to patient risk

The service had escalation policies and guidance in relation to a deteriorating woman or baby. These included clinical practice care pathways for early recognition of severely ill pregnant women (review date, April 2020) and transfer of a sick new born to neonatal services (review date, September 2019). There was also guidance on physiological observation of women in maternity (review date, May 2020), and a maternity services new born resuscitation policy (review date, February 2020).

There were robust midwifery led care policies, which identified the criteria for women being able to deliver within the unit (review date, June 2019) and at home (review date, January 2020). We reviewed the birth centre guidelines and found comprehensive guidance about admittance criteria and risk factors, review and monitoring of higher risk (outside of criteria) women, multidisciplinary care planning, admission and assessment, labour and birth, management of obstetric emergencies, and transfer procedures.

The trust reported that in the 12 months prior to our inspection, there were no out of criteria women admitted to the birth centre.

Risk assessment at antenatal booking took place for all women to determine whether individuals were high or low risk. We reviewed three sets of patient records at the site and found good documentation of medical, social and mental health assessments, which were fully completed in all cases. Care pathways (including changes to the care pathway) were clearly documented in all the records reviewed.

The unit undertook intermittent auscultation for low risk women during labour, in line with national guidance (NICE 2014. Intrapartum care: care of healthy women and their babies during childbirth, Clinical Guideline 109). Senior staff told us that the service was considering employing a ‘fresh ears’ approach to intermittent auscultation, whereby a second midwife would confirm the fetal heart rate pattern every hour.

Midwifery staff identified women showing signs of early deterioration by using an early warning assessment tool known as the Modified Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. Unfortunately, none of the three care records inspected on site required use of MEWS tools; so, we could not comment on their use.
The service confirmed that they had not completed a MEWS audit in the 12 months prior to our inspection, to ensure compliance with monitoring and escalation of deteriorating patients. However, we did see evidence that MEWS was included within the scope of the 2017 annual record keeping audit, and the service continued to implement and embed recommendations and learning from the 2016 audit. Following the inspection, the trust provided us with provisional findings from the 2018 Mews Audit (completed August 2018), that had been ongoing at the time of our inspection. As these had not been quality assured we do not present them here. The trust informed us that once data analysis was finalised, a full audit report would be completed which will include an action plan to address the improvement requirements identified.

At our previous inspection in May 2017, we found there was not a regular programme of skills and drills at the birth centre. At our recent inspection, all staff we spoke with said they had been involved in regular skills and drills training.

There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to Pinderfields Hospital. Staff informed us as soon as they were concerned they called for an emergency response ambulance.

Data provided by the trust showed 91% of applicable maternity services staff had received resuscitation training as of June 2018. The Women’s and children’s group action plan (2017) detailed that neonatal resuscitation training was to be provided to all maternity service staff as mandatory training, with an implementation date of August 2018.

During our recent inspection, we observed good swab counting practices in the surgeries inspected at Pinderfields Hospital. However, this could not be evidenced by audit results. The Clinical Audit Programme and Action Plan Obstetrics/Midwifery Update (July 2018), did not show that a ‘swab count’ audit had been conducted in 2017 to 2018. A ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. Therefore, we were unable to comment on the use and documentation of ‘swab counts’ in the wider service.

Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

**Midwifery and nurse staffing**

The service used Birthrate Plus to enable a comprehensive review of midwifery staffing numbers based on the different models of care. A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the current funded establishment of 222.87 midwives was correct for the activity in the maternity service at the trust; and took into account women that may birth in other units but whom required antenatal and postnatal care from the maternity service.

Most midwives at the service were employed as ‘rotational midwives’. Staff worked within their preferred area of work forming a ‘core’ element, but they could be redeployed to work on other wards/department within the service at short notice. For example, to cover unplanned sickness or to cover planned sickness or annual leave on other departments.

Birth centre establishment staffing at the location was comprised of two midwives and one healthcare assistant. On-call cover for the birth centre was provided by the community midwifery team.

There were two band seven community midwifery team leaders at the service. One responsible for the Pontefract community team and Wakefield community team, and one responsible for the Dewsbury community team.
The service had an escalation policy (review date August 2019). The policy provided guidance for
maternity staff about clinical decision making and required actions in the event of a situation where
capacity and complexity of workload presented challenges in the delivery of a safe maternity
service for women and their babies.

At the commencement of shifts (07.30/20.00) the shift lead midwife at the birth centre documented
and assessed workload and staffing within their unit and documented this on the birth centre data
entry sheet every four hours.

The Pinderfields birth centre shift lead Midwife contacted the birth centre at commencement of
each shift to obtain an overall view of workload and staffing at the birth centres.

If issues arose regarding staffing or workload at the birth centres in hours, the birth centre
manager/maternity matron for community and outpatients was informed to provide support with
the redeployment of staff, or redirection of women to another birth centre.

If support could not be obtained from other birth centres or staff within the outpatient areas, the
labour ward manager/maternity matron for inpatients was contacted to support management.

If issues arose out of hours, the shift lead midwife at Pinderfields birth centre was required to liaise
with the labour ward coordinator. They would then consider re-allocation of staff already on duty or
rostered to work, or call community midwifery support according to the escalation rota following
discussion with the midwifery advisor on-call.

The trust did not provide us with midwifery and nurse staffing information for individual locations.
Therefore, the data below is presented for maternity services at trust-level. The one exception to
this is bank and agency staff use, for which location level information is presented.

We also note, that despite good overall staffing figures across the service, we were concerned that
staff were not allocated properly across the service to meet service need. This is explained in
more detail in the Responsive (access and flow) section of the report.

**Planned vs actual**

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper
was submitted to the Trust Board in June 2018. The paper detailed the current funded
establishment of 222.87 midwives was correct for the activity in the maternity service. During our
inspection, senior staff told us that 217 WTE midwives were contracted within the service. This
equated to a nursing and midwifery staffing fill rate of 97.4% within maternity services at the trust.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 1.0% in maternity services,
meeting the trust’s 9% target.

During this period, there was a 3.6% vacancy rate among community midwives at the trust.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

During our inspection, senior staff told us that the trust maternity service had funding for 228.87
WTE midwives, and 217 WTE midwives were contracted. This meant there was 11.87 WTE
vacancies at trust level. This equated to a vacancy rate of 5.19%, which met the trust’s 9% target.

Senior staff described they had gained permission to overrecruit midwifery staff, and there was a
rolling programme of recruitment. They told us that 9.2 newly qualified WTE midwives had been
appointed in in June 2018; and were scheduled to commence employment October 2018. They
also advised us that they would be advertising for additional post shortly, as part of their rolling
programme of recruitment.
**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 13.4% in maternity;

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Total Staff Leavers</th>
<th>Average WTE Establishment</th>
<th>Turnover Rate</th>
<th>12% Target Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; midwifery staff (Qualified nurses)</td>
<td>28.0</td>
<td>215.1</td>
<td>13.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>2.0</td>
<td>8.3</td>
<td>24.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>30.0</td>
<td>223.4</td>
<td>13.4%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the 12% turnover target for qualified nursing or midwifery staff.

During this period, there was a 11.3% turnover rate among community midwives at the trust, and a 14.3% turnover rate among maternity ward midwives at the trust.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Senior staff told us that the turnover rate had improved in the latter half of the reporting period described above. They attributed higher rates of turnover earlier in the reporting period to post-reconfiguration of services. The trust provided data that showed from October 2017 to March 2018, the midwifery turnover rate was 5.31% (14 leavers). This was within the trust target of 12%. The service attributed current trends in staff turnover to both the retirement of staff and the transient nature of newly qualified midwives. The service was undertaking an age profile review of the midwifery workforce to inform future workforce and succession planning.

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 6.3% for qualified nursing and midwife staff in maternity services.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff sick days</th>
<th>Staff days</th>
<th>Sickness rate</th>
<th>4.8% Target Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>4,959.6</td>
<td>79,088.5</td>
<td>6.3%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>189.8</td>
<td>2,645.1</td>
<td>7.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>5,149.4</td>
<td>81,733.6</td>
<td>6.3%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the sickness rate target of 4.8% for qualified nursing or midwifery staff.

During this period, there was a 7.5% sickness rate among community midwives at the trust.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017 - March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the sickness rate among midwifery staff was marginally above trust target of 6.3%, and stood at 6.76%. However, that the sickness rate was improving.
During our inspection, senior staff told us that the sickness rate among midwives had improved, and in June 2018 stood at 4.6%; which was within trust target. In addition, that the sickness rate for community midwives had been reduced to 5.1%.

**Bank and agency staff usage**

The table below shows the total number and proportion of shifts available, those filled by bank qualified midwifery bank and agency staff, and shifts left unfilled from April 2017 to March 2018 in maternity services at the location:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of shifts available</td>
<td>1460</td>
</tr>
<tr>
<td>Number of shifts filled by bank staff</td>
<td>48</td>
</tr>
<tr>
<td>Proportion of shifts filled by bank staff</td>
<td>3.3%</td>
</tr>
<tr>
<td>Number of shifts filled by agency staff</td>
<td>25</td>
</tr>
<tr>
<td>Proportion of shifts filled by agency staff</td>
<td>1.7%</td>
</tr>
<tr>
<td>Number of shifts filled by bank or agency staff</td>
<td>73</td>
</tr>
<tr>
<td>Proportion of shifts filled by bank or agency staff</td>
<td>5.0%</td>
</tr>
<tr>
<td>Number of shifts not filled</td>
<td>111</td>
</tr>
<tr>
<td>Proportion of shifts not filled</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

As can be seen, there was low reliance on the use of bank and agency staff at this location.

The service used NHS professionals (NHSP) to fill gaps in the planned number of staff. A number of substantive staff were signed up to NHSP, and the agency also provided a number of familiar staff to the maternity unit, this provided continuity.

Senior management had implemented changes in the provision of absence staffing cover since our last inspection. They had encouraged more substantive staff to join NHSP, increasing bank staff availability. They also offered unfilled shifts as overtime to contracted staff, if not filled by NHSP staff, two weeks before shifts commencing. Agency staff were now used as a last resort.

We compared spending on bank and agency staff in November 2017 to spending in March 2018. We saw that agency staff spend had fallen by 92%, and bank staff spend had increased by 77%. Figures were not inclusive of overtime spend.

**Midwife to birth ratio**

The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance; Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007).

From January 2017 to December 2017, the trust had a ratio of one midwife to every 26.88 births. This was similar to the England average of one midwife to every 25.46 births, and met the recommended minimum ratio of one midwife to every 28 births. The service did not include maternity support workers within the establishment.

(*Source: Electronic Staff Records – EST Data Warehouse*)

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017 - March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the midwife to birth ratio as 1:28 at the trust. This met the recommended minimum ratio.
The birth centres operated under a flexible staffing model, supported by community midwives, to deliver one-to-one (1:1) care in established labour. Low risk postnatal women within the units were supported by the healthcare assistants. Therefore 1:1 care was not reported upon in the midwifery-led care setting, as the staffing model and escalation procedure meant that all care was 1:1.

There were 21.76 WTE midwives in the Dewsbury community midwifery team. The average community caseload within the Dewsbury community team was 123 women per WTE midwife (based on number of bookings), this was not in line with national recommendations. The current recommended Birthrate plus ratio, allowing for some changes in allowances and the NICE Guidance since 2009, is 96 cases per WTE midwife.

The service had recently begun reporting midwifery caseloads against the number of live births, in addition to against the number bookings (from May 2018). Following this methodology, the community caseload within the Dewsbury community team was 85 women per WTE midwife (based on number of live births). Using the live birth denominator is a useful additional measure of community midwifery activity. However, current guidance is calculated using cases (number of bookings). In the guidance, the term ‘cases’ is used rather than ‘births’ as not all women will have delivered in the local maternity unit, so will not be included in the total births for the obstetric unit. The total number of cases will reflect the local population of women having delivered along with those that may not complete their pregnancy.

**Medical staffing**

Maternity services offered at Dewsbury and District Hospital were midwife-led. At the site, medical staff who provided clinics for women who required obstetric-led care or review closer to home were based at Pinderfields Hospital. Therefore, we do not report on medical staffing per se at this location.

**Records**

We saw secure storage facilities for records at the midwife-led unit. Electronic records were also kept, and procedures for safe storage were in line with data protection requirements.

Handheld notes were carried by women throughout pregnancy, in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3.

The service completed bi-annual record keeping audits. We reviewed the audit completed in December 2017, which was submitted to the Maternity Clinical Governance Group. Across maternity services at the trust, a total of 167 sets of maternity case notes and / or hand held notes were audited. These included 57 antenatal records, 71 intrapartum records, and 39 postnatal records.

The results showed improved compliance with antenatal record keeping, particularly around documentation of CTG monitoring when compared to the previous audit. There was also a significant compliance increase in full recording of mental health risk assessments, and birth plans. Recording compliance for intrapartum drug sensitivity/allergy and verbal consent for all intrapartum procedures had increased since the last audit was undertaken. Postnatal documentation of perineal trauma (if appropriate) was also improved.

Areas of concern included a fall (from the previous audit) from 97% to 89% in recording maternal pulse on the first auscultation of the fetal heart, and also a reduction from 98% to 75% in recording the fetal heart every 5 minutes for over a minute within the second stage of labour. Similarly, a reduction from 78% down to 58% was seen in palpating and documenting maternal pulse every 15 minutes in the second stage of labour.
Following the audit, an action plan was put in place. Ongoing activity to monitor changes in compliance included a random sample of eight maternity records per month at each location from January 2018, to be collated for the next record audit report.

We reviewed three sets of patient records and found that a risk assessment for obstetric / medical history and social history were carried out in all cases. Care pathways (including changes to care pathways) were clearly documented in the records reviewed.

We did not inspect any intrapartum or postnatal records at the site, so we are unable to comment on the use of this documentation.

During the inspection, we saw three separate entries on the maternity risk register relating to maternity service records; these were rated as presenting a moderate to high risk. All three entries centred around issues with the main maternity record software system. Staff we spoke with during our inspection reported the system was sometimes cumbersome to navigate, but overall, they found the system adequate. The senior management team were acutely aware of the risks involved, and were currently reviewing options to implement a new paperless system when the current software license expired (2019). The service had also developed a task and finish group to plan, evaluate and adopt a paperless postnatal record. We reviewed relevant risk register entries and saw that risks had been appropriately monitored and mitigated. We also saw there was an electronic maternity system action plan 2018 in place, which showed progress towards against a new digital maternity plan for the service.

**Medicines**

Medicines that required storage at a low temperature were stored in specific locked fridges. Medicines that did not require refrigeration were stored in locked cupboards and trolleys in all clinical areas. Fridge and cupboard temperatures were monitored remotely.

The emergency drugs boxes we inspected were all appropriately sealed and within date.

Records showed the administration of controlled drugs were subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded. Records showed controlled drugs were checked in line with trust policy.

The trust audited the safe storage of medication on maternity wards and clinics twice a year, and reported results to the Medicines Optimisation Group and at a divisional level.

The April 2018 medicines audit showed that Dewsbury maternity services were compliant with the safe and secure storage of medicines. However, the audit did find some expired medication in the midwifery-led unit. At our inspection, we did not find any expired medications at the service.

During our inspection, we identified some paper copies of patient group directions (PGDs), that allowed midwives to administer certain medicines without a prescription, were out of date. Individual midwives who could administer the medicine under the PGD were not listed and had not signed the individual authorisation form attached to the end of each PGD, as required by trust policy.

Staff had access to up to date electronic medicine policy guidelines via the trust intranet and the trust pharmacist visited the wards and departments weekly.
Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant), with 2 incidents (40% of total incidents).

- VTE meeting SI criteria, with 1 incident (20% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant), with 1 incident (20% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only, with 1 incident (20% of total incidents).

(Source: Strategic Executive Information System (STEIS))

In addition to those described above, a serious incident had occurred in maternity services May 2018. This was classified as Maternity/Obstetric incident meeting SI criteria: baby only.

None of the serious incidents reported within maternity services during the period May 2017 to May 2018 had occurred at Dewsbury and District Hospital.

The trust had a policy for reporting incidents, near misses and adverse events in maternity services. Staff we spoke with said they were encouraged to report incidents and were aware of the process to do so.
Staff reported incidents on the trust’s electronic incident-reporting system. The governance midwife and consultant obstetrician (both RCA trained) lead on serious incident investigations, supported by multidisciplinary colleagues as necessary.

We reviewed three completed serious incident root cause analysis (RCA) reports and associated actions plans, which identified areas of good practice and areas of concern, contributory factors and recommendations. We observed appropriate referral to external agencies, and inter-agency working, where appropriate.

We reviewed minutes of Maternity Clinical Governance Group meeting minutes (December 2017 to June 2018) and found discussion of serious incidents, RCA reports, clinical incidents and the RCA action log were standing agenda items.

During our inspection, we reviewed the maternity service RCA action log and found three outstanding actions; these had been granted an extension and appropriately monitored. We saw actions from one serious incident placed on hold due to external agency involvement. An additional 11 actions from a recent serious incident were due to be added to the log, pending commissioner approval.

Between July 2017 and June 2018, there were 316 incidents reported by maternity services at the location. The trust provided summary information data, which thematically categorised incidents. However, we were not able to ascertain levels of harm (for example, no harm, moderate harm, or severe harm) from the data. Nor were we able to identify specific areas of the maternity services to which incidents related.

As shown in the table below, of the 316 incidents, most related to ‘transfer’ (n49, 15.5%), ‘problem with the referral from primary to secondary care’ (n37, 11.7%), and ‘appointment’ (n34, 10.8%). We amalgamated 22 categories where four or less incidents per category were reported over the 12-month period.

<table>
<thead>
<tr>
<th>Incident category</th>
<th>Total incidents reported at location</th>
<th>Proportion of incidents reported at location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer</td>
<td>49</td>
<td>15.5%</td>
</tr>
<tr>
<td>Problem with the referral from primary to secondary care</td>
<td>37</td>
<td>11.7%</td>
</tr>
<tr>
<td>Appointment</td>
<td>34</td>
<td>10.8%</td>
</tr>
<tr>
<td>Test results / reports</td>
<td>29</td>
<td>9.2%</td>
</tr>
<tr>
<td>Adverse events that affect staffing levels</td>
<td>20</td>
<td>6.3%</td>
</tr>
<tr>
<td>Patient's case notes or records</td>
<td>17</td>
<td>5.4%</td>
</tr>
<tr>
<td>Laboratory investigations</td>
<td>15</td>
<td>4.7%</td>
</tr>
<tr>
<td>Communication between staff, teams or departments</td>
<td>15</td>
<td>4.7%</td>
</tr>
<tr>
<td>Possible delay or failure to Monitor</td>
<td>13</td>
<td>4.1%</td>
</tr>
<tr>
<td>Patient's case notes or records</td>
<td>12</td>
<td>3.8%</td>
</tr>
<tr>
<td>Administration of assessment</td>
<td>7</td>
<td>2.2%</td>
</tr>
<tr>
<td>Medication error during the prescription process</td>
<td>6</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
At our previous inspection in May 2017, we identified that the service was learning from incidents, but were not informing staff why practice had changed. During our recent inspection, we found staff were able to tell us about incidents that had occurred and learning from these.

The service used internal communication methods to inform staff of learning and changes to practice. Monthly maternity clinical governance reports were distributed (emailed directly) to staff and showed the number, location, severity of incidents, and incident themes. Comparative data was presented from previous months to map incident numbers, locations and themes over time.

Where relevant, the governance report highlighted discrepancies between incident reports and maternity dashboard figures, and noted these as missed opportunities for learning and good practice to be shared. It was conceded in the report that some incidents may have been reported under other categories.

We saw evidence of specific learning events and investigations posted in clinical areas for staff to review. The service used a trust-wide monthly newsletter and weekly safety brief to inform staff of learning and changes to practice, and to keep staff informed of risks which faced the directorate. We observed the safety brief displayed in clinical areas. Staff we spoke with across the service told us that incidents and learning were also discussed at the labour ward forum, team meetings, and handovers.

The Duty of Candour (DoC) is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm. Duty of candour was evidenced in the completed serious incident investigation and meeting minutes we reviewed. The staff we spoke with at the midwifery-led unit said they were open and honest with women if things went wrong.

**Safety thermometer**

The service submitted data to the national maternity safety thermometer. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced ‘harm free’ care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This is a point of care survey that is carried out on a single day each month on 100% of postnatal mothers and babies. Data is collected from postnatal wards, women’s homes and community postnatal clinics.

Maternity safety thermometer data was presented for all maternity settings at the trust, hospital care, midwifery-led unit care, and community care.

However, when we reviewed the data, we found significant gaps in reporting for midwifery-led care and community care; sometimes in excess of six months. This might be attributed to the low number of women available for participation in these services on the days surveys were conducted.
We therefore do not report on safety thermometer data for this location.

The maternity service submitted data to the maternity safety thermometer, but did not routinely use the tool to support safety and improvement; as they considered more accurate and informed tools exited which better supported this. The service considered the tool unrepresentative of actual performance. This, they said, was due to significant restrictions on the data, including snapshot data and low numbers which are not representative of all service users, and inconsistency in data collection methodologies across organisations. The service instead said they valued maternity dashboard, FFT and patient surveys (which they considered provided richer and more representative data), alongside themes from complaints, incidents, and serious incidents to inform an accurate picture of the quality of the service. We saw evidence that this evidence drove improvements. The service noted there is currently a national review of the safety thermometer as to its value as an improvement tool.

Is the service effective?

Evidence-based care and treatment

The delivery of care and treatment provided to women was based on guidance issued by professional and expert bodies. This included the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence based practice.

Policies and procedures were available on the trust’s intranet and were approved by the clinical governance group. Staff told us that policies and guidance could be accessed on the trust intranet, which they found easy to navigate. All the electronic policies and guidance we reviewed across the service were found to be current and reflected quality standards and national guidance.

The minutes of Maternity Governance Meeting minutes (December 2017 to June 2018) showed monitoring and review of controlled documents within the service.

The manually held policies and clinical guidelines we saw on site were seen to be within date with version control.

At our previous inspection in May 2017, we found a lack of additional audit activity following the amalgamation of services on the Pinderfields site.

At our recent inspection, we saw that a quality data and audit midwife had been recruited in April 2018. Prior to this, the post had been vacant for more than 12 months. The quality data and audit midwife was responsible for producing the annual maternity audit programme, in conjunction with the governance midwife. In addition, for allocating and supporting staff with clinical audit, to ensure the plan was delivered within timescale.

We reviewed an update to the clinical audit programme and action plan for obstetric and maternity services (dated to July 2018). We saw several local audits marked as ongoing that had surpassed dates of estimated completion. In some cases, audits had been significantly delayed; for example, the Antenatal Risk Assessment (level 1) audit was due to be completed by March 2017.

The governance midwife and IHoM informed us that the quality data and audit midwife had made good progress with backlogs since their appointment, and had prioritised activities for completion. We saw evidence of this, and noted that national audit programmes were on-track overall. However, we saw several local audits marked as ongoing that had surpassed dates of estimated completion. For example, the antenatal risk assessment (level 1) audit was due to be completed by March 2017. We also learned that the service had not conducted a MEWS audit in the 12 months prior to our inspection. The service told us this was ongoing and later provided evidence of completion in the form of preliminary data (August 2018); although this had not been quality assured. We could not find evidence in the audit programme that a ‘fresh eyes’ audit had been
conducted in 2017 to 2018. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). We also could not see that a ‘swab count’ audit had been conducted in 2017 to 2018; but did see that a ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. The service reported that it did not undertake pain audits.

The service reported that audit activities were on-track to be completed within adjusted timescales. We saw audit activity was entered on the maternity risk register and this was appropriately monitored and reviewed. However, we noted significant delays with the local maternity audit programme overall.

**Nutrition and hydration**

The service had a current infant feeding policy, based on UNICEF UK Baby Friendly Initiative standards for maternity and neonatal (UNICEF, 2014), relevant NICE guidelines (NICE, 2008; NICE, 2017), and the Healthy Child Programme (DOH, 2009).

The trust had implemented the United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards, and had achieved full accreditation.

Midwives were required to attend a one-day UNICEF Breastfeeding and Relationship building course within six months of their start date.

There was an infant feeding coordinator at the trust. Their role included training staff, division of frenulotomy (tongue-tie) clinics, and supporting breastfeeding mothers on the postnatal ward and in the community.

Since our last inspection in May 2017, the service had increased their breastfeeding initiation target from 60% to 70%. Maternity dashboard data for Bronte birth centre showed that from July 2017 to June 2018, the proportion of women who had commenced breast feeding within 48 hours of delivery was 75.1% at the location. This was above the trust’s target.

Women who chose to formula feed their baby were asked to bring their own powered formula and bottles into the unit. Women were supported to make their formula correctly throughout their stay.

The service worked with community services and public health to provide continuity of support for breastfeeding once women had left the hospital. The trust supported local, volunteer-run, weekly, breastfeeding cafes, which women could attend for support and advice.

Refreshment facilities were available in antenatal clinic waiting area. Women and their families were able to have light meals and snacks during their time on the birth centre.
Pain relief

The birthing centre had had two birthing pools and equipment to support active labour; such as active birthing couches, birthing balls, and TENS machines.

Pharmacological pain relief options included diamorphine, meptazinol (meptid), and pethidine. Women attending the birthing centre who requested epidural analgesia were transferred to the labour ward at Pinderfields Hospital.

The service did not actively promote alternative therapies, for example, hypnobirthing. However, we were told they supported women who chose this method of pain relief; and we saw patient information leaflets on display that described the potential benefits of different holistic pain relief methods.

Patient outcomes

Standardised Caesarean section rates and modes of delivery

From July 2017 to June 2018, maternity dashboard data for Bronte birth centre showed the proportion of instrumental deliveries was 0%.

Over the same period, the proportion of non-interventional (normal) deliveries was 100%.

Within this timeframe, 38.2% of deliveries at the location were water births.

From July 2017 to June 2018, maternity dashboard data for Bronte birth centre showed the proportion of pre-term babies delivered before 37 weeks gestation was 0.0%.

Over the same period, maternity dashboard data for Bronte birth centre showed the proportion of babies with low birth weight (under 2200g) born at term was 0.0%.

Maternity active outlier alerts

As of May 2018 the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the MBRRACE audit. The latest MBRRACE report (June 2018) showed their stabilised and risk-adjusted extended stillbirth rate (per 1,000 births) was 3.78. This was similar to the average for the comparator group rate of 3.74.

Their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.08. This was slightly higher than the average for the comparator group rate of 4.95.

MBRRACE data was based on information collected from January 2016 to December 2016 (and published in the most recent MBRRACE report available at the time of inspection).

(Source: MBRRACE UK)

The service had a MBRRACE Perinatal Confidential Enquiry action plan (2017). The action plan showed the service was compliant against all applicable recommendations, with the exception of one. The action plan detailed that the home birth guideline was currently being updated to include practical guidance around resuscitation of a baby born in extremis and out of hours in their service; with deadline set for August 2018.

The service completed a gap analysis against the MBRRACE Saving Lives, Improving Mothers’ Care UK report in December 2017. The associated action plan listed 28 actions required to
achieve compliance. The service was partially or non-compliant with respect to approximately half of the recommendations listed. Actions to achieve compliance were assigned a lead, and completion date. Outstanding actions were due to be completed between September 2018 and December 2018.

The service had completed an Each Baby Counts Recommendations gap analysis, and had produced an associated action plan (October 2017). The action plan detailed 18 recommendations, of which 17 were completed. An outstanding recommendation, to employ a ‘fresh ears’ approach to intermittent auscultation, was under consideration and the service was in discussion with other trusts as to the approach to take. A completion date of October 2018 had been set for the outstanding item.

The Maternity Services Still Birth Group Meeting minutes for July 2018 reported that the trust were fully compliant with the Saving Babies Lives Stillbirth Bundle; a care bundle for stillbirth prevention, through improved antenatal recognition of foetal growth restriction. In addition, the service had launched a multidisciplinary still birth group, to oversee projects and initiatives to reduce the stillbirth rate within the trust.

From July 2017 to June 2018, maternity dashboard data for Bronte birth centre showed no stillbirths had occurred at the location.

Maternity dashboard data for Bronte birth centre showed that from July 2017 to June 2018, the proportion of normal deliveries resulting in a 3rd or 4th degree tear was 2.8%. The maternity dashboard did not display a trust target for 3rd or 4th degree tears. However, rates appeared slightly higher than Yorkshire and Humber averages for the period April 2017 to December 2017 (the most recent data available at the time of inspection), which ranged from 2.1% to 2.4% per quarter. We saw that there had been no third or fourth degree tears at the service between March 2018 and June 2018.

Maternity dashboard data for the location showed that from July 2017 to June 2018, the proportion of women who experienced a postpartum haemorrhage (PPH) of more than 1500mls at the birth centre was 0.6%. Over the same period, the proportion of women who experienced a PPH of more than 2500mls was 0.0%. The maternity dashboard did not display a trust target for PPHs. However, rates were much better than Yorkshire and Humber averages between April 2017 to December 2017, which ranged from 5.7% to 6.6% per quarter (PPH more than 1500mls) and 2.4% to 4.6% (PPH more than 2500mls).

From October 2017 to June 2018, there were 67 transfers from the birthing centre to the labour ward at Pinderfields Hospital. We were unable to calculate the proportion of women transferred, as the service had changed their data collection and recording methods in October 2017, to monitor transfers by site.

Data provided by the trust showed the stage of pregnancy (antenatal, intrapartum, postnatal) at which the transfer took place, and reasons for transfer.

Data showed that of the 67 transfers, 55% (n37) were antenatal transfers, 25% (n17) were intrapartum transfers, and 35% (n13) were postnatal transfers. Of the 17 intrapartum transfers, most were recorded against failure to progress in the first stage (n2, 12%) or second stage (n3, 18%) of labour, or identification of fetal heart abnormalities (n2, 12%).

Staff told us that transfers had been clinically appropriate and that there had been no occurrences of women inappropriately attending the birthing centre. It was trust policy to report any inappropriate transfers or attendances as incidents using the Datix incident reporting system.

For intrapartum transfers, the average time from a call being made for ambulance transfer to ambulance arrival at the birth centre was 13 minutes. The average time from the birth centre to arrival at Pinderfields Hospital was 24 minutes.
We were told there was ongoing review and monitoring of trends in transfer rates, and any practice issues highlighted would be addressed by the consultant midwife and raised in the service’s clinical governance, quality, and performance meeting agendas.

From July 2017 to June 2018 there were 13 women booked for home births with the Dewsbury community team. Of these, 2 women (15%) were transferred to Pinderfields Hospital for delivery.

Competent staff

Matrons and managers monitored staff training monthly. They allocated staff to training and used the appraisal system to identify the need for additional training.

Appraisal rates

Following our inspection, the trust provided appraisal data for staff within maternity services. Data showed that as of June 2018, 100% (all) of 417 eligible maternity services staff at the trust had received an appraisal.

Following the change in legislation, (April 2017) the statutory role of the supervisor of midwifery (SOM) no longer existed. The service had implemented a role called midwifery advisors. Midwifery advisors were on call for 24 hours for independent advice and support as required.

Midwifery staff we spoke did not report any problems accessing midwifery advisors for supervision, guidance and advice. However, we did see that the ratio of senior midwives to midwives at the trust was low compared to the national average. From January 2017 to December 2017, the ratio of senior midwives to midwives at the trust was 0.13; this was considerably lower the national average of 0.24.

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017 - March 2018’ paper was submitted to the Trust Board in June 2018. The paper outlined that the service is currently working on a project to develop the midwifery support workers’ (health care assistants) skills set. This will involve a new job description, competency packages and reconfiguration of allocation into certain clinical areas to support the delivery of safe care.

The paper detailed that skill mixing is essential to ensure midwives are effectively deployed and supported by other colleagues, such as maternity support workers who are giving clinical care. In addition, that current data and the consensus of expert midwifery opinion is that a 90% to 10% split between midwives and non-midwifery support staff allows for flexible and sustainable services.

Band 5 staff had a structured programme of rotation as part of their preceptorship programme. The midwifery preceptorship programme provided key consolidation areas for all midwives to become confident in implementing their role in the rotation programme. This ran over a full two year period. Staff spent six months on the antenatal and postnatal wards, six months at the delivery suite, three months in the along-side birth centre (all at Pinderfields Hospital), and nine months in a community placement in any of the three trust locations.

To maintain skills and confidence, band 6 ‘core’ midwives were rotated on a short ‘up-date rotation’ for three months into the labour suite. This followed from staff feedback, that being called to the main obstetric unit caused some apprehension.

Community midwives rotated into the labour suite for two weeks each year; to help keep up their competencies. This commenced in June 2018. We saw that midwives from each of the three community teams at the trust had either had staff rotate into the service, or were rostered to do so.

Senior staff reported that any member of maternity staff can request to rotate to another area, and this was facilitated by the Maternity Matron.
Seven midwives working at Bronte birth centre were new born and infant physical examination (NIPE) trained. In addition, nine midwives in the Dewsbury community team were NIPE trained.

The trust was unable to provide bereavement training completion rates for maternity services staff. They reported that processes were in place to ensure the data is captured going forward, as part of the service’s mandatory training for midwives’ update. We saw evidence of a programme of upcoming training sessions, and a schedule for all midwifery and nursing staff in the service to be trained in the next three years. Bi-annual maternity specific study days were also available (see Caring, emotional support section).

**Multidisciplinary working**

There was a formalised structure of meetings in place to enable multidisciplinary team working. These included monthly maternity governance meetings and perinatal mortality and morbidity meetings.

We observed good multidisciplinary working in clinical areas. All staff, including those in different teams and services, were involved in assessing, planning and delivering women’s care and treatment.

The service participated in regional and local multidisciplinary team networks, in areas such as fetal medicine.

We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.

Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists, and pharmacy.

Midwives at the hospital and in the community worked closely with the trust safeguarding team, GPs, and social care services, when dealing with safeguarding concerns or child protection risks.

Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals when needed.

There were clear processes in place for multidisciplinary working in the event of maternal transfer by ambulance from the birth centre or homebirth to hospital.

Emergency training (YMET) and skills and drills training included multidisciplinary staff.

In addition, mandatory bereavement training study days were available to all maternity, neonatal, gynaecology and obstetrics staff. Staff from A&E were recently invited to attend the sessions, to assist them with women attending with a fetal loss within their department.

**Seven-day services**

The birth centre offered a 24/7, seven days a week service.

Antenatal clinics and the antenatal day unit were available five days per week, Monday to Friday, during working hours.

On-call community midwives were available twenty-four hours a day, seven days a week.
Health promotion

There was a lead midwife for public health at the trust.

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in infant feeding, substance misuse, diabetes, and perinatal mental health.

Maternity dashboard data for Bronte birth centre showed that from July 2017 to June 2018, the proportion of women smoking at time of booking was 15.1%. The proportion of women smoking at time of delivery was 14.0%; which was within the trust target of 18.3% and similar to most recently available regional averages.

Yorkshire and Humber maternity dashboard data for the period April 2017 to December 2017 showed the average proportion of women smoking at time of delivery ranged from 13.4% to 13.6% per quarter (mean 13.5%).

A smoking cessation lead midwife had recently been appointed to improve smoking at time of delivery rates for pregnant women within the Wakefield locality. The role included empowering staff to assist women to stop smoking during pregnancy. We saw that new pathways for smoking in pregnancy had been ratified at the February 2018 maternity governance meeting.

A range of health promotion patient information leaflets was available at the service. These included, immunisation in pregnancy guidance by Public Health England, ‘Why weight in pregnancy matters’, UNICEF ‘Building a happy baby: A guide for parents’, and a guide for management of long term health conditions in pregnancy. A selection of smoking cessation material was also on display.

Pregnant women were able to take advantage of 10 free (‘pregnant tums and new mums’) swimming sessions, at various locations across the local area.

Information about antenatal classes and support groups were also displayed. These included a free six-session ‘Nurturing parents – preparation for parenthood’ course.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 95% for completion of level 1 (core) Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) mandatory training, and 85% for level 2 (role specific) MCA and DoLS mandatory training.

Trust level

A breakdown of compliance for MCA and DoLS mandatory training courses for applicable staff in maternity services at the trust as of June 2018 were provided.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA and DoLS Level 1</td>
<td>449</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>MCA and DoLS Level 2</td>
<td>186</td>
<td>251</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>MCA and DoLS Level 3</td>
<td>26</td>
<td>44</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust met the completion target for MCA and DoLS Level 1 training (100%), but did not meet completion targets for MCA and DoLS Level 2 (74%) and Level 3 (59%) training.

Women we spoke with confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.

Staff we spoke with clearly articulated consent procedures, and the use of Gillick competency for consent of patients under the age of 16 years.

We saw that ‘Consent to examination or treatment’ patient information leaflets were available in clinical areas.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

**Friends and family test performance (antenatal), The Mid Yorkshire Hospitals NHS Trust**

![Graph](image)

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

The trust performance dropped slightly to 92% in September 2017, compared to the England average of 97%. The trust performance for antenatal in the latest month, March 2018 was 97%, the same as the England average, 97%.

**Friends and family test performance (birth), The Mid Yorkshire Hospitals NHS Trust**

![Graph](image)

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Each pair of lines below is for each month, the top number is the England Score, the bottom number is the Trust Score.
The trust performance (% recommended) for birth services in the latest month, March 2018 was 100%, compared to the England average of 97%.

**Friends and family test performance (postnatal community), The Mid Yorkshire Hospitals NHS Trust**

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.  
*(Source: NHS England Friends and Family Test)*

**CQC Survey of women’s experiences of maternity services 2017**

The trust performed similar other trusts for 12 out of 16 questions in the CQC maternity survey 2017; two questions were not applicable to responses gained about maternity services at the trust.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.59</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.08</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.50</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.94</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.08</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.20</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.71</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Table of Care during Labour and Birth and Hospital After the Birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.74</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.40</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.12</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.97</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.61</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.04</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>7.89</td>
<td>Worst performing trusts</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

The trust performed better on care during labour and birth, when spoken to in a way they could understand.

The trust performed worse than other trusts for the care patients received in hospital for treating women with kindness and understanding after the birth of their baby.

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

A recent survey of maternity service users was commissioned by the CCG in conjunction with the Maternity Voices Partnership (MVP) group. Data was gathered from 502 women in early 2018. Membership criteria for the MVP included having given birth at the trust in the last four years. The survey focussed on postnatal care, but many women shared their experiences of their entire maternity journey.

Throughout the survey, there were many positive comments about staff, care and feeding support received whilst in hospital. For example, when asked what was good about their experience, comments included, “1:1 care form midwife”, “fantastic /supportive / friendly care from midwife” and “kept well informed”.

In addition, quantitative data was largely positive. For example, on a scale of 1 to 10 with 10 being excellent, 75% of women rated their maternity experience overall as 6 or above; and 26% rated it as a 10.

However, there were also a number of negative comments (n62) around staff attitude, consistency of staff, quality of care, feeding support, lack of information and support.

The survey related to the service as a whole, and findings cannot be reliably assigned to a particular location. In addition, we were unable to gauge the extent to which women’s expressed concerns captured experiences of care since our last inspection of the service.
We noted the comparatively low number of formal complaints (n11) received about services at the location from April 2017 to February 2018, and the relatively high number of formal compliments (n52) received (see Responsive, Learning from complaints and concerns section).

Women and their partners we spoke with during our inspection of the birth centre were positive about the care they received.

During our inspection we observed staff interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.

Staff we spoke with told us they were positive about providing good quality and compassionate care to women.

**Emotional support**

There were guidelines and care pathways in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.

The trust had a named maternity bereavement midwife. In addition to providing bereavement training, the role included providing advice, training and support to staff caring for and supporting bereaved parents within the service.

A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss. The bereavement midwife worked collaboratively with the consultant lead, to ensure women received appropriate support following pregnancy loss.

The trust was unable to provide bereavement training completion rates for maternity services staff. They reported that processes were in place to ensure the data is captured going forward, as part of the service’s mandatory training for midwives’ update.

The service reported that, from June 2018, the maternity bereavement training session had been included within the midwives’ mandatory training update (with 25 training spaces offered every month). As recommended by Yorkshire & Humber and Stillbirth and Neonatal Death Support (SaNDS), training was required every three years. The service said that the training programme and schedule would ensure that all midwifery and nursing staff were up to date with the now mandatory requirement within the next year.

In addition to mandatory bereavement training, staff were able to attend bespoke maternity bereavement study days; which took place every six months. At the time of inspection, we saw one study day had taken place so far in 2018, with a further two planned later in the year. Study days could accommodate 15 to 20 participants, and were available to all maternity, neonatal, gynaecology and obstetrics staff. Staff from A&E were recently invited to attend the sessions, to assist them with women attending with a fetal loss within their department.

Senior staff told us that funding was available for staff wishing to attend further external training, that included obtaining consent for post-mortem examinations.

The multi-faith chaplaincy service offered bereavement support to those who had lost a baby through miscarriage, stillbirth or neonatal death; and had a 24-hour on-call service including out-of-hours cover for emergencies via hospital switchboards.

There was a perinatal lead midwife in the service, who had been appointed to improve services for vulnerable women and those with perinatal mental health concerns.

Staff said perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.
A survey of maternity service users was commissioned by the CCG in conjunction with the Maternity Voices Partnership (MVP) group (see Compassionate care section, above). The summary information received noted negative comments that included those around lack of support. However, there was no evidence to suggest that comments related to services provided at this location.

The service scored similar to other trusts for questions in the 2017 CQC maternity survey that related to support. For example, for the question, “at the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?”.

Birth centre staff we spoke with during our inspection were proud of the level of emotional support offered by the service. They told us how women were supported at the centre, and those who needed extra help with infant feeding were able to stay on the unit overnight.

Understanding and involvement of patients and those close to them

Women were given the opportunity of making an informed choice about all available birth settings appropriate and safe for their clinical need and risk.

There were guidelines for standalone and along-side birth centres, and for homebirths. These provided guidance on which women were eligible for midwifery led care, risk assessments and record keeping, and actions to take should the woman develop risk factors requiring obstetric opinion.

Lower risk women were able to deliver in any of the birthing suites provided by the service, and in their own homes; and could also opt to deliver at the labour ward if they so wished.

There was a Maternity Voices Partnership (MVP) group in place at the trust. Women who were pregnant or have had a baby in the last four years could meet together with staff from the maternity services. This included midwives, obstetricians, breast feeding peer supporters, and staff from the Clinical Commissioning Group (CCG) who commission services on behalf of local people.

Over the past year the MVP had discussed the re-configuration of maternity services and received presentations from Homestart family charity, PANDAS (Pre and Postnatal Depression Advice and Support) and the trust Matron for Children who discussed care from health visitors and wider children’s services.

A survey of maternity service users was commissioned by the CCG in conjunction with the MVP group (see Compassionate care section). The summary information received noted negative comments that included those around lack of information.

Data summaries from the survey suggested that women’s negative comments and perceptions predominantly related to hospital-based services at Pinderfields Hospital. However, the survey related to the service as a whole, and findings cannot be reliably assigned to a particular location.

In the CQC maternity survey 2017, maternity services at the trust were among the best performing for speaking to women in a way they could understand during labour and birth. Responses to several other questions pertaining to offering information and inclusion in decision-making were similar to other trusts.

During our recent inspection, we spoke with two women, and an accompanying partner. They described the staff were supportive and encouraged them to ask questions.

From February to April 2018, data from ‘Plus 5’ responses suggested women using antenatal and birth services at the trust experienced good understanding of and involvement in their care. For example, women were asked if they were always given time to ask questions or discuss pregnancy in antenatal services, and an average of 93% agreed they had. Over the same period,
93% to 95% agreed they were always spoken to in an understandable way. In labour and birth services, 93% to 95% of women agreed that they were always involved in decisions about their care, and 98% to 100% agreed they always had concerns raised taken seriously.

Following CCG and MVP maternity survey feedback, the trust’s maternity service have planned an ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. The event will bring together new mothers and staff with the aim of improving the experience of women using its maternity services. Senior staff also told us that findings from the ‘always event’ workshop would be used to refresh the maternity services patient experience action plan.

Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From June 2016 to December 2017 the bed occupancy levels for maternity were generally higher than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

From July 2017 to June 2018, there were 307 deliveries at Bronte birth centre.

Data provided by the trust showed from July 2017 to June 2018 the average bed occupancy rate at the birth centre was 10%. Data followed DoH (KH03) definitions, which means an occupied bed day is defined as one which is occupied at midnight on the day in question.

The maternity service at Dewsbury provided midwifery-led care via antenatal clinics and an antenatal day unit, and a stand-alone birthing centre. The service had consultant-led clinics, so women who required obstetric review could receive care closer to home.
The premises and facilities were appropriate for the services provided there.

Women whose pregnancies were low-risk were able to choose to deliver at home, in a stand-alone or alongside midwifery-led birthing centre, or in the labour ward at Pinderfields Hospital.

The population served by Dewsbury and District Hospital was culturally and ethnically diverse, and women attending clinics and the birthing centre during our inspection were from a variety of backgrounds. None of the women we spoke with expressed any concern about staff understanding of their personal, cultural, social, or religious needs.

Partners were encouraged to stay in the birthing centre with mothers and babies following delivery, until discharge. There was a postnatal room with a double bed for mothers and their partners.

Community-based maternity services were provided from a number of locations within the area; predominantly in GPs’ surgeries, children's centres, and women’s own homes.

### Meeting people’s individual needs

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in safeguarding, perinatal mental health, bereavement, diabetes, twins (multiple pregnancy), and infant feeding.

The service also employed a teenage pregnancy midwife, who specialised in supporting pregnant women under 20 years of age.

The trust offered a range of spiritual and holistic healthcare services at each site. The trust’s chaplaincy team offered a point of contact with the appropriate faith community, and there was a hospital chapel and prayer room at the location. The chaplaincy service was available to visit wards/units to meet with patients, carers, and staff; and an out of hours service was available.

Funeral options were offered within maternity services following a pregnancy loss, and the trust had a protocol to offer joint cremation or burial for babies/foetuses lost up to 24 weeks gestation. An allowance was made for Islamic communities or any other individual who choose to have individual burial, if they so wished.

Face-to-face foreign language interpretation services were provided by Kirklees Council. Telephone based interpreting services were provided by 'BigWord'; who also provided translations of written documents into either audio or written format. British Sign Language (BSL) services were also available.

We saw several maternity service patient information leaflets were available in a variety of languages on the trust's internet pages.

The trust had been working with an external company to establish feedback mechanisms which supported access for harder to reach groups. FFT cards were available in large print on yellow card and easy to read versions. A freephone interpretation service could be accessed for feedback in many languages and translated versions of the survey were also available via the trust website. Interpreters, accessed via the trust, had been given written information to support the verbal translation of feedback from patients they saw.

The trust access group met quarterly with stakeholders with disabilities to identify and improve services. Specialist learning disabilities nurses were available at the trust, who led a learning disability patient experience group.

### Access and flow
Maternity dashboard data for the location showed that from July 2017 to June 2018, 92.4% of initial antenatal bookings were undertaken before 13 weeks. This was above the trust target of 90%.

However, staff in antenatal clinics across maternity service sites (including at this location) told us that they experienced difficulty offering women follow-on appointments due to increased demand and limited capacity. During our inspection, staff at Pinderfields Hospital showed us a capacity list of over 150 women waiting to be booked for antenatal follow-up appointments across the service, and we saw no additional slots were currently available until October 2018.

Senior management we spoke with recognised the high demand for antenatal appointments at the location, and across maternity service sites. As of April 2018, three entries on the maternity risk register identified moderate to high risks in relation to antenatal clinic capacity, the availability and capacity of obstetric staff for clinics/review, and increased demand for scan requests.

The Maternity Clinical Governance meeting action log (June 2018) identified concerns around midwives reviewing high risk scans and making plans on when to bring women back to clinic, and midwives working and making decisions above and beyond their role at Pinderfields Hospital (entry dated to April 2018). The entry noted it was also not the role of the on-call team. It was stated that there was not enough consultant/doctor capacity in the antenatal clinic for all women to be seen. It was identified that the day unit needed a designated doctor to review these women and a dedicated clinic time for women being referred for repeat scans. Entries dated to May 2018 and June detailed the issue had been escalated, a standard operating procedure prepared, and these would be discussed at an antenatal clinic summit (scheduled for September 2018).

The management team and senior staff described the implementation of several actions to try and improve access and flow across the antenatal service (which were noted on relevant maternity risk register entries). These included training two midwifery sonographers, extending the antenatal day unit opening hours at the Pinderfields site, development of a midwifery care pathway for scanning and scan review, and an antenatal booking and risk assessment audit (the latter is due to be completed August 2018).

The management team explained flexibility had been introduced within the antenatal service, by directing low risk women to midwifery-led day units (at Pontefract and Dewsbury) where possible. On-call obstetric consultants were able to review CTG results remotely, and we saw evidence of this during our visit. However, some midwifery staff we spoke with described delays in obtaining medical review, and sometimes felt they were working beyond their role.

There was an antenatal clinic task and finish group in place at the service, and we reviewed an action log compiled by the group dated to July 2018. The log detailed 39 actions, 32 of which were completed, and five were in progress. Ongoing actions included setting up a sub-group to agree a diabetic pathway and improvements to the antenatal clinic booking system. We saw that outstanding actions were due to be completed by August to September 2018.

An antenatal clinic summit was being organised for September 2018 to review ideas for rapid resolution across the antenatal service.

Information received from the trust following the inspection showed that the concerns with insufficient antenatal clinic capacity to meet the volume of patients was due to insufficient medical staff to cover the antenatal clinics. This resulted in 150 women at the time of inspection and across the trust, waiting for an antenatal appointment. Antenatal clinic capacity was recorded on the trust risk register and identified as a priority.

From the 1st August 2018, the situation improved with the new intake of doctors. The gaps on the rotas had reduced and extra capacity clinics had been opened to accommodate the volume of patients. This meant that although there were 28 patients awaiting an appointment (as of mid-September 2018), processes were in place for these patients to be seen within the required timeframe. We saw that the ‘capacity list’ was monitored on a daily basis. Patients who could not
be booked for a further appointment due to clinic capacity, were escalated to the antenatal clinic lead consultant. They reviewed the individual patient records and agree a suitable date for the women to be seen; without impact to their care. As of September 2018, we were assured that all patients had been seen within the appropriate timescale. However, should this not be possible, that a formal risk assessment would be undertaken and documented. This had not been required to date.

The service had an Escalation and Closure Policy (review date August 2019). The policy provided guidance for maternity staff about clinical decision making and required actions in the event of a closure. This is a situation where capacity and complexity of workload present challenges in the delivery of a safe maternity service for women and their babies, and the service must be closed to new patients. It stated that closure would only be considered when all other potential solutions were exhausted.

The trust provided data that showed the number of closures at the location. Bronte birth centre had closed on seven separate occasions; all between February 2018 and June 2018. Closures ranged from 12 to 48 hours on each occasion.

Following the maternity service escalation policy, data suggested closures had occurred to meet maternity service demand at Pinderfields Hospital.

Learning from complaints and concerns

There was a trust complaints policy and procedure in place, which staff we spoke with were aware of.

We observed patient advice and liaison service (PALS) information leaflets on display in the areas we visited.

We also saw trust information leaflets on display in the waiting area about how to make a comment, compliment or complaint.

Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform their manager.

Summary of complaints

From April 2017 to February 2018, there were 88 complaints about maternity services. The trust took an average of 20.4 days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be closed within 30 days.

Of the 88 complaints received about maternity services at the trust, 11 related to maternity services at the location. No complaints were received about community midwifery services at the location.

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<thead>
<tr>
<th>Dewsbury &amp; District Hospital</th>
<th>Antenatal Clinics/Day Unit</th>
<th>5</th>
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<tbody>
<tr>
<td>Bronte Birth Centre</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Community Midwives</td>
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Number of compliments made to the trust

From April 2017 to February 2018, there were 127 compliments were received and recorded about maternity services at the trust.
Of these, 52 (41%) were made in relation to maternity services at the location. Most of the 41 compliments received were about care provided in the birth centre (77%).

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<tr>
<th>Dewsbury &amp; District Hospital</th>
<th>Antenatal Clinic</th>
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<tbody>
<tr>
<td>Bronte Birth Centre</td>
<td>40</td>
<td>52</td>
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<tr>
<td>Community Midwives</td>
<td>3</td>
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We saw evidence of learning from complaints and concerns. In response to FFT feedback, each inpatient ward area across the service had produced a ‘welcome to the ward’ leaflet that outlined meal times, discharge procedures, telephone numbers and ward information (completed October 2017 and updated March 2018). We saw these on display during our visit.

There was a Maternity services patient experience action plan 2018/2019. The plan listed 17 actions informed by patient feedback, designed to improve patient experience. We saw 14 actions had been completed, one action had been removed, and two actions were ongoing.

Following CCG and MVP maternity survey feedback, the service had planned an ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. Senior staff also told us that findings from the ‘always event’ workshop would be used to refresh the maternity services patient experience action plan.

**Is the service well-led?**

**Leadership**

Maternity services formed part of the Women’s Services, in the Families Services, Clinical Support and Facilities division. A head of clinical service for obstetrics and gynaecology, a patient services manager, and an interim head of midwifery (IHOM) led the maternity service.

The senior management team had changed since our previous inspection in May 2017, and was relatively new. At the time of our most recent inspection, the head of clinical services had been in post for eight months, and the IHoM had been in post for seven months.

The management team described that had started to make ‘in roads’ into the service, and to implement the changes necessary to improve quality of care. During our inspection, we observed cohesive team working; with support offered from clinical leads and the deputy director of operations (Families and Clinical Support Services).

There was a matron for community and outpatients, who had day to day responsibility for the service. At the location, there was a midwife (band seven manager) responsible for the birth centre and a midwife (band seven manager) responsible for antenatal services.

There was a band seven community midwifery team leader who was responsible for the Dewsbury community team.

Midwives reported they were supported by their managers, who would undertake clinical shifts to support teams and keep their competencies up to date.

Student midwives at the location reported that they felt supported by managers, and their colleagues.

Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme and through one-to-one meetings with managers.
Vision and strategy

The trust’s vision was “to achieve an excellent patient experience each and every time”.

There was a maternity governance and risk management pathway (review date July 2020); which stated that the aim of the maternity service was “to provide all our women and babies with high quality care that is delivered in a safe environment”.

The trust had a maternity service improvement plan (March 2018), designed around high-level themes the service aspired to achieve. Themes centred on building strong leadership, building the capability and skills of staff, sharing progress and lessons learnt, and improving data capture and knowledge. A multidisciplinary meeting identified five focus areas to improve safety within the maternity service; leadership and teamwork, staff training and development, clinical governance, perinatal mental health, and ensuring quality maternity data. There was an action plan for each core focus area, which detailed the recommendation, actions implemented to achieve it, designated lead, and evidence of implementation. At the time of viewing, all but one of the actions (which was ongoing) had been completed; but during our inspection several areas of the maternity service (especially in relation to access and flow) were identified as in need of quality improvements, with no clear strategy in place to address these issues.

There was also a maternity services patient experience action plan 2018/2019. The plan listed 17 actions informed by patient feedback, designed to improve patient experience. We saw 14 actions had been completed, one action had been removed, and two actions were ongoing.

An ‘always event' workshop was planned for September 2018, to bring together new mothers and staff with the aim of improving the experience of women using its maternity services. Senior staff told us feedback from the event would be used to revise and update the patient experience action plan.

We also saw evidence of action plans arising from engagement with maternity services staff at the trust. For example, an action log arising from a ‘little conversation’ event with community midwives earlier in the year.

Culture

The Freedom to Speak Up Guardian (FTSUG) submitted six-monthly progress reports to the trust board. In March 2018, the FTSUG report showed that from September 2017 to March 2018, the greatest number of concerns raised from one specific area came from staff within maternity services (seven), both acute and community. We saw that a concern (raised in 2017) included claims of a culture of bullying and cronyism in maternity services. Discussions had taken place between the FTSUG and the Matron and Head of Service for the area concerned.

During our inspection, the IHOM reported that at appointment, she had been given a mandate to focus on the culture within the service.

The IHOM said that she had implemented a programme of ‘little conversations’ to engage with maternity staff, and one had already taken place with community midwifery staff. Further ‘little conversations’ were planned for birth centre and labour ward staff.

The IHoM said she was approachable and accessible, and welcomed concerns from staff. During our inspection, we observed that the IHoM had visited a member of midwifery staff at another trust site to discuss their concerns.

The IHoM reported that regular meetings took place with Royal College of Midwifery union representatives, to discuss “what happens on the shop floor”.
The IHoM recognised that culture could not be changed “overnight”, but felt that “a corner had been turned”. At the time of inspection, the IHoM told us that she liaised with the FTSUG, and no concerns had been raised by maternity services staff with the guardian since March 2018.

At our recent inspection, we saw the service had implemented a number of initiatives to improve staff morale.

The service had introduced ‘My Maternity Star’ awards. These allowed staff to nominate maternity colleagues who had made positive contributions to colleagues and patients.

There was also a monthly governance newsletter (“Maternity Measured”), with a more in-depth issue issued every six months. The March 2018 issue focused on celebrating changes in the 18 months since reconfiguration of the service. The management team thanked staff for their hard work and highlighted achievements and reasons for staff to be proud. Community team leaders and birth centre managers also submitted messages.

We observed strong team working, with specialised and multidisciplinary staff working cooperatively and with respect for each other’s roles. Most staff spoke positively about the culture at the service, and were proud of the quality of care they delivered.

Some maternity service staff we spoke with during our inspection raised concerns about capacity and workload, which impacted on their perceptions of culture within the service. Concerns predominately related to antenatal service capacity (please refer to Responsive section). Staff described feeling “frustrated” about capacity and ‘bottle necks’ in the system.

**Governance**

There was a Maternity Governance and Risk Management Pathway policy document (review date July 2020). The key aims of the pathway were to develop a more dynamic approach to risk management, embed risk management systems and processes and promote a culture where risk management is everybody’s business, and to clearly define roles and responsibilities for risk management and governance at a directorate level.

There was a defined governance structure. There were divisional and obstetric governance leads for the service. The service employed a full-time governance midwife who worked across sites; and a deputy governance midwife was employed two days per week. Staff were aware of their roles and responsibilities in relation to governance.

There were several layers of governance quality assurance. These included the antenatal screening and neonatal screening governance committee, the labour ward forum, maternity governance group, women’s governance group, family and clinical support services divisional governance group, trust quality committee, and trust board.

The maternity governance group met monthly to discuss, monitor and review all aspects of clinical governance. The role of the group was to provide assurance to the divisional governance group, regarding all matters relating to clinical quality and patient safety of the obstetrics and gynaecology services provided by the trust.

The obstetric governance lead and governance midwife led on serious incident root cause analysis (RCA) reports, and worked in conjunction with the matron or manager responsible for the service area.

A quality data and audit midwife had been recruited April 2018. Prior to this, the post had been vacant for more than 12 months. The quality data and audit midwife had oversight of the maternity service audit programme. The governance midwife and IHoM informed us that the quality data and audit midwife had made good progress with backlogs since their appointment, and had prioritised activities for completion. The service reported that activities were on-track to be completed within
adjusted timescales. We saw audit activity was entered on the maternity risk register and this was appropriately monitored and reviewed. However, we noted significant delays with the local maternity audit programme overall.

During our inspection, we reviewed the maternity service RCA action log and found appropriate monitoring and review of actions. There were three outstanding action, but these had been appropriately monitored and an extension granted.

Management of risk, issues and performance

There was a Maternity Governance and Risk Management Pathway policy document (review date July 2020). It set out clear guidance for the reporting and monitoring of risk.

Senior staff we spoke with were comfortable escalating issues to the senior management team, and received appropriate feedback. Members of the senior management team were confident escalating issues to the head of women’s services, divisional leads, and (if necessary) directors and the trust board.

The service had a current risk register. This was a live document, comprising of a list of risks, and description summaries, in order of priority. The risk register was generated electronically from the trust’s electronic risk management system (DATIX) and reflected risks placed on the system.

All new maternity risk assessments were discussed on a monthly basis at the maternity risk register meeting and decisions made about the appropriateness of grading, and inclusion. The group also discussed any re-grading or risks which have been resolved from the risk register.

The risks of greatest concerns in relation to clinical and non-clinical issues were monitored by the divisional governance group. Risks that scored 12 and above were reported to the trust patient safety panel and the clinical executive group.

At our previous inspection of the service in May 2017, we saw that the maternity risk register contained a large number of risks, and many had a review date in the past. This led to concern that there was a lack of oversight by senior managers.

At our most recent inspection, we saw good monitoring and oversight of the risk register. Risk register entries were subdivided into risks with ongoing actions, and tolerable risks. We saw evidence of several risks that had been resolved in the past 12 to 18 months. We also saw evidence of appropriate discussion and grading of risks in recent maternity risk register meeting minutes.

The senior management team and senior governance staff were aware of risks facing the service. This included high demand for antenatal services and limited capacity across sites. The service had implemented measures to mitigate risks and try to resolve ‘bottle necks’ and increase capacity in the antenatal service, and an antenatal clinic summit was planned for later in the year (please see Responsive section). The senior management team were relatively new, and we saw they were aware of the issue and had made some headway in working to address this. However, at the time of inspection, we saw performance in this area remained limited.

We found an overview of serious incidents, incidents and complaints presented in monthly maternity clinical governance meeting minutes (December 2017 to June 2018). We also saw evidence of more in-depth review of incidents in maternity governance reports. For example, as submitted to the monthly maternity governance committee in May 2018. The report included a summary of incidents, the number, location, and severity of incidents, and incident themes. Comparative data was presented from previous months to map incident numbers, locations and themes over time. Midwifery red flag events were also detailed and thematically mapped. Root cause analyses from previous (completed) investigations were presented, alongside learning from RCAs.
There was a trust-wide maternity dashboard and location specific maternity dashboards (for Pinderfields Hospital, Pontefract Hospital, and Dewsbury and District Hospital). These were discussed at monthly maternity governance meetings. The service submitted data to the Yorkshire and Humber regional maternity dashboard. This meant the service could compare its performance against other local trusts and Yorkshire and Humber averages.

**Information management**

During our inspection, we saw that controlled documents (such as policies and guidelines) were within date, version controlled, and reflected current national guidance.

The service completed comprehensive bi-annual record keeping audits. At the time of inspection, the most recent report available was published December 2017. Audit results were benchmarked against previous findings and targets, and showed areas of improved compliance and areas of concern. Results were categorised using a RAG (red, amber, green) rating system. We saw that an action plan had been put in place to improve compliance. Ongoing activity to monitor changes in compliance included a random sample of eight maternity records per month at each location from January 2018, to be collated for the next record audit report.

During the inspection, we saw three separate entries on the maternity risk register relating to maternity service records; these were rated as presenting a moderate to high risk. All three entries centred around issues with the main maternity record software system. Staff we spoke with during our inspection reported the system was sometimes cumbersome to navigate, but overall, they found the system adequate.

The senior management team were acutely aware of the risks involved, and were currently reviewing options to implement a new paperless system for when the current software license expired (2019). The service had also developed a task and finish group to plan, evaluate and adopt a paperless postnatal record. We reviewed relevant risk register entries and saw that risks had been appropriately monitored and mitigated. We also saw there was an electronic maternity system action plan 2018 in place, which showed progress towards against a new digital maternity plan for the service.

**Engagement**

There was a Maternity Voices Partnership (MVP) group in place at the trust. Women who are pregnant or have had a baby in the last four years could meet together with staff from the maternity services. This included midwives, obstetricians, breast feeding peer supporters, and staff from the Clinical Commissioning Group (CCG) who commission services on behalf of local people.

Over the past year the MPV had discussed the re-configuration of maternity services and received presentations from Homestart family charity, PANDAS (Pre and Postnatal Depression Advice and Support) and the trust Matron for Children who discussed care from health visitors and wider children’s services.

The trust collated and mapped independent/externally collected patient experience data from Picker patient experience surveys and summaries, the NHS patient safety programme, and unannounced ‘walkabouts’ by the CCG. They also produced ‘Plus 5’ maternity reports, which asked questions based on feedback from an ‘always event’ held with women 2017; which had been added to FFT cards.

Following CCG and MVP maternity survey feedback, the trust’s maternity service have planned an another ‘always event’ workshop for September 2018, utilising the Institute for Health Care
Improvement’s (IHI’s) Always Events Framework. The event will bring together new mothers and staff with the aim of improving the experience of women using its maternity services.

The service has also planned to implement a ‘15 steps challenge’ review of services, which will involve service users, commissioners, trust patient experience staff and an executive director. The ‘15 steps’ toolkit was developed by NHS England for MVP groups to help understand what service users experience as they access local maternity care. The toolkit aligns with NHS priorities for maternity care as outlined in the Better Births report published in 2016. The toolkit has been discussed with the local MVP group. Pending ratification at the service’s patient experience sub-committee, the service plans to roll the toolkit out in September 2018.

The trust provided us with a maternity staff communication action plan (dated to June 2018), which identified poor staff outcomes (gathered from engagement and survey activities), and actions to be taken to deliver improvements in communication. Entries identified action leads, due dates, and evidence of review and completion. We saw that a number of actions related to staff recruitment, increasing staff satisfaction, valuing staff, and progression planning. Of the 14 entries listed, nine had been completed and five had ongoing actions; and were due for review between August and November 2018.

The service had implemented a programme of “little conversations” to engage with maternity staff, and regular meetings took place between the IHoM and RCM union representatives.

Learning, continuous improvement and innovation

During our inspection, we found a lack of local audit activity to encourage continuous improvement; this had been ongoing since our last inspection of the service.

We reviewed an update to the clinical audit programme and action plan for obstetric and maternity services (dated to July 2018).

We saw that the quality data and audit midwife had made progress with backlogs since their appointment, and had prioritised activities for completion. We also noted that national audit programmes were on-track overall. However, we saw several local audits marked as ongoing that had surpassed dates of estimated completion. For example, the antenatal risk assessment (level 1) audit was due to be completed by March 2017. We also learned that the service had not conducted a MEWS audit in the 12 months prior to our inspection. The service told us this was ongoing and later provided evidence of completion in the form of preliminary data (August 2018); although this had not been quality assured. We could not find evidence in the audit programme that a ‘fresh eyes’ audit had been conducted in 2017 to 2018. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). We could not see that a ‘swab count’ audit had been conducted in 2017 to 2018; but did see that a ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. The service reported that it did not undertake pain audits.

The service had successfully engaged with staff and encouraged more substantive staff to join NHS Professionals (NHSP), and had begun offering unfilled shifts as overtime to staff. Agency staff were now used as a last resort. The service had seen a significant increase in the proportion of bank (NHSP) staff used to fill unfilled shifts, and a decrease in the use of agency staff.

Outcomes from patient engagement activities had been used to inform some improvements within the service. For example, following FFT feedback, the service had introduced ‘welcome to the ward’ leaflets for each inpatient area.

The service had commissioned an external company to undertake a thematic review of key sources of maternity feedback in late 2017. An internal co-design workshop was held to identify priorities for improvement in the areas of antenatal, labour and birth, postnatal wards and postnatal community. Five different questions relating to these priorities had been added as a
monthly local survey on each of the Maternity FFT cards, at the four points of the maternity pathway.

In addition, senior staff also told us that findings from an MVP ‘always event’ and a ‘15 steps’ workshop in September 2018 would be used to refresh the maternity services improvement plan.

However, whilst we recognised significant work undertaken by the service to collate and map patient feedback, and upcoming work to engage with service users, we were concerned that patient experience action plans in place at the time of inspection were not sufficiently robust, and the service had not acted in a timely way to implement changes.

Since our last inspection, the service had implemented an MBRRACE Perinatal Confidential Enquiry action plan, MBRRACE Saving Lives, Improving Mothers’ Care action plan, and an Each Baby Counts action plan. We also found that the trust were now fully compliant with the Saving Babies Lives Stillbirth Bundle.

We saw there was a task and finish group for antenatal clinic services, and that a clinic summit had been organised to evaluate access and flow in the antenatal service. However, we were not always assured work was being delivered at a sufficient pace.
Outpatients

Facts and data about this service

Total number of first and follow up appointments compared to England

![Graph showing number of first and follow up appointments](image)

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from July 2017 to June 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>428,260</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>186,826</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>172,077</td>
</tr>
<tr>
<td>The Mid Yorkshire Hospitals NHS Trust</td>
<td>1,091</td>
</tr>
<tr>
<td>This Trust</td>
<td>788,254</td>
</tr>
<tr>
<td>England</td>
<td>106,661,135</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at The Mid Yorkshire Hospitals NHS Trust from July 2017 to June 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Most staff had completed their mandatory training. Training figures supplied by the trust were trust wide and were not broken down by site. Outpatients had an overall compliance of 97% for core subject training, with a trust target of 95%. For role specific subjects, the trust target was 85%, outpatients achieved a compliance rate of 80% overall.

Staff we spoke with told us that it had been difficult finding time to do their mandatory training due to staff shortages. The department manager told us that all staff were booked on to training.

A monthly training matrix was sent to the service to identify gaps in training. A mandatory training coordinator for the department would ensure staff knew when they had to book their training.

The training data shows compliance for all staff in outpatients, apart from medical staff. Data for medical staff would be captured under the relevant speciality.

Mandatory training completion rates

The trust set a target of 85% or 95% for completion of mandatory training, depending on the module.
Trust level
A breakdown of compliance for mandatory training courses from up to the end of June 2018 at trust level for all staff in outpatients is shown below:

### Core MAST Compliance (target 95%)

<table>
<thead>
<tr>
<th>CORE SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Diversity Awareness - Once in Employment</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Infection Control - Every 2 Years</td>
<td>29</td>
<td>289</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 1 Theory - Every Three Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 1 - Every 3 years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Fire Safety - 1 Year</td>
<td>22</td>
<td>296</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Health and Safety Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>30</td>
<td>288</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>93</td>
<td>2769</td>
</tr>
</tbody>
</table>

### Role Specific MAST Compliance (target 85%)

<table>
<thead>
<tr>
<th>ROLE SPECIFIC SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Conflict Resolution - Once in Employment</td>
<td>16</td>
<td>110</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Health and Safety Level 2 - Every 2 Years</td>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 2 practical - Every Three Years</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Medicines Management Level 2 - Every Three Years</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 2 - Every 3 years</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>
There were safeguarding policies and procedures in place for staff to follow, which included protocols for suspected female genital mutilation (FGM). FGM is defined by the World Health Organisation as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

Staff we spoke with could tell us the process they would follow to report any safeguarding concerns and make a referral. Staff could access advice and support from the trust safeguarding team.

**Safeguarding training completion rates**

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module.

**Trust level**

A breakdown of compliance for safeguarding training courses April 2017 to March 2018 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>13</td>
<td>20</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. Overall training compliance at Dewsbury hospital was 70.4%, this had been identified on the risk register and was mainly due to staff sickness.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Data provided by the trust after our inspection showed a higher compliance rate, however this was not broken down in to the different levels of training.

<table>
<thead>
<tr>
<th>NHS</th>
<th>Safeguarding Adults Level 1 - 3 Years</th>
<th>2</th>
<th>316</th>
<th>318</th>
<th>99%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
<td>318</td>
<td>99%</td>
</tr>
</tbody>
</table>

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean and tidy. Dirty utility rooms were clean and free from clutter. Personal protective equipment, such as gloves, were available and we saw staff wearing these as appropriate.

Hand gel was available in all areas. Staff were seen to comply with the arms bare below the elbow policy and were seen washing their hands. We spoke with 11 patients and only one patient said they did not think staff washed their hands.

Each clinic room had a record sheet to indicate that cleaning had taken place. On a whiteboard in the corridor was a cleaning rota, staff placed stickers on the calendar when the cleaning had taken place.

Audit results were displayed in all areas. We saw that for June 2018 main outpatients had achieved 98% for hand hygiene compliance and 95% for bare below the elbows. The phlebotomy department had achieved 100% for both hand hygiene and bare below the elbows. Audit data showed an average compliance rate with infection prevention and control of 99%.

**Environment and equipment**

The main outpatient department, ophthalmology outpatients and phlebotomy were all located together. There was no electronic check in desks and no electronic patient call. In main outpatients, patients waited in a main waiting area until they were called through to a smaller waiting area where the clinic was taking place.

Most equipment was up to date with electronic servicing, apart from two pieces of equipment that said a service was due in January 2018. The medical physics department serviced all equipment on a rolling programme.

One crash trolley was shared between main outpatients, ophthalmology outpatients and phlebotomy. We saw completed checklists for July, up to the date of inspection, to indicate that daily checks had taken place.

There were systems in place for the correct segregation and disposal of waste, including sharp items.
Assessing and responding to patient risk

At our last inspection, there was a backlog of patients waiting. Some of the waiting lists had been clinically validated but others hadn’t been. At this inspection, staff we spoke with told us that waiting lists had been reduced and that they now had administrative and clinical validation. There was a validation team, which employed 15 validators and was in the process of appointing eight more. Each validator was responsible for a different speciality. An outpatient follow up procedure was used to minimise the clinical risk of patients who were waiting for follow up appointments. Within one month of being overdue, a follow up waiting list report was produced which was reviewed by a patient access team leader, who did an administrative validation. Any possible capacity would be identified and instructions given to booking clerks. Within two months of becoming overdue where no capacity was identified, the list of patients, by consultant, was presented to the weekly speciality control tower, who either identified where capacity could be made available or identified the patient for clinical validation by the consultant. Those plans were reviewed at the following week’s control tower meeting to ensure they had been completed. At three months of becoming overdue, the volume of patient’s overdue by three months or more was escalated to the weekly patient access control tower and patient service managers had to work with their clinical teams to put action plans in place to reduce the volume to zero. Any specialities that were off plan to deliver reduction were escalated to the Executive Access, Booking and Choice Steering Group.

However, when we asked the trust to provide evidence that all patients in the backlog had been clinically validated, they could not provide this evidence. They told us it was not possible to provide this evidence as the list changed daily, with patients removed or added to the list. It was identified on the patient administration system that seven percent of the existing backlog had been through a full administrative and clinical validation process. Thirty nine percent of patients had been added to the backlog in the last four weeks and the remaining patients were part way through the process.

In ophthalmology, at our last inspection there were backlogs in new and follow up appointments. Since then, there had been an independent external review and staff had worked to an ophthalmology improvement plan. In a newsletter to staff, we saw that the backlog of follow up appointments had been reduced and there were no new patients waiting since February 2017 and no new glaucoma patients waiting since August 2017. The longest backlog patient for ophthalmology was from May 2017.

Staff could tell us the process they would follow for any unwell patient in the department. They would transfer them to the emergency department, which was located across the corridor, and then they would be transferred to Pinderfields hospital. The department kept some early warning score charts in case they needed to use them.

A daily huddle was held in the main outpatient’s department to ensure any information staff needed to be aware of was passed on.

Nurse staffing

The trust has reported their staffing numbers for outpatients below for the period from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse staffing</td>
<td>16</td>
<td>19</td>
<td>85%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Main outpatients had seven qualified nurses and 13 healthcare assistants. On each shift, one qualified nurse covered one area of the department supported by healthcare assistants.

At our last inspection, there was no matron in post. This position had been recruited to and the new matron had been in post since September 2017. When we spoke with the matron he told us that there was a workforce review in progress, which would be used to write a business case for increased staffing.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 13.6% for nursing staff in outpatients. This is worse than the trust target of 9%.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 18.5% for nursing staff in outpatients. This is worse than the trust target of 12%.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 13.6% for nursing staff in outpatients. This is worse than the trust target of 4.8%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

The sister for main outpatients at Dewsbury hospital told us that their sickness rate was 23.8%. There were two staff members on long term sick leave and prior to this there had been a further two staff members on long term sick leave. Service leads told us that sickness rates were closely monitored.

**Medical staffing**

There were no medical staff specifically for the outpatient’s service. The medical staff that held clinics were accountable to the specific divisions they worked for.

The individual specialities managed and arranged cover for their clinics.

**Records**

The outpatient department used a combination of written and electronic records. The paper records only contained an outcome form and patient labels. Previous history was available on the electronic record.

The department used a ‘paper light’ system, which meant that clinicians wrote up their notes following the consultation and these were then taken and scanned on to the electronic patient record.

Staff we spoke with told us they had no problems accessing patient’s medical records for the clinic.


Medicines

All medicines were stored securely and were in date. Pharmacy automatically topped up supplies.
Prescription pads were stored securely and had a completed signing in and out sheet.
Fridge temperatures were monitored centrally and pharmacy informed staff if the temperature fell out of the required range.

Incidents

The trust used an electronic incident reporting system. Staff who we spoke with were aware how to report incidents.
Learning from incidents was shared in a monthly newsletter produced by the matron.
Staff we spoke with understood the principles of the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Following a review of reported incidents between April 2017 and March 2018, we found five serious incidents reported for the ophthalmology service where deterioration in vision may have been due to a delay in appointments. The reports showed a thorough investigation and immediate actions taken, including a review of the glaucoma follow up backlog to ensure those patients at greatest risk were prioritised for urgent review and the creation of additional clinics. An independent review of the service was requested. We saw that duty of candour had been adhered to and the patient’s kept fully informed.

Safety thermometer

The safety thermometer was not used in outpatients. However, outpatients did record and display hand hygiene and bare below the elbow audit results.
They also monitored the number of falls that had occurred in the department. We noted that there had been a fall in the department the day before our visit, staff had completed an incident form for this.
**Is the service effective?**

**Evidence-based care and treatment**

Staff had access to up to date policies and guidelines on the trust intranet. Patient’s care and treatment was planned and delivered in line with national guidance, including the National Institute for Health and Care Excellence (NICE).

A NICE tracker ensured that new guidance and alerts had timeframes and a reporting framework for implementation of the guidance.

Audits were done to ensure practice guidelines followed national guidance.

**Nutrition and hydration**

A water cooler was available in the waiting area of main outpatients.

On a Thursday afternoon a volunteer worked in the main outpatient department, part of the role involved offering patients hot drinks.

There were no vending machines available for drinks or snacks.

**Pain relief**

Pain relief was not routinely administered in the outpatient’s department and pain management tools were not used.

**Patient outcomes**

The outpatients service did not routinely monitor patient outcomes. This was managed by the individual specialities.

Physiotherapists completed an outcome form after the clinic consultation. They were trialling outcome measures.

**Follow-up to new rate**

From February 2017 to January 2018,

- The follow-up to new rate for Dewsbury & District Hospital was lower than the England average.
Follow-up to new rate, The Mid Yorkshire Hospitals NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff

Appraisal rates

From April 2017 to March 2018, 78% of staff within the outpatient’s department at the trust received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals who required an appraisal</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met 85% target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>71</td>
<td>56</td>
<td>78.9%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>282</td>
<td>220</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>19</td>
<td>12</td>
<td>63.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>376</td>
<td>292</td>
<td>77.7%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The appraisal rates provided by the trust were not site specific or broken down. Although the completion rate for qualified nursing staff was 63.2%, this was only seven staff members that had not had an appraisal.

Following our inspection, we were provided with updated appraisal figures, however these were not broken down by staff group. These showed a compliance rate of 95% for outpatients overall.
The sister in main outpatients told us that her staff appraisal rates for Dewsbury were at 100%.

All staff we spoke with told us they had regular appraisals and these were an opportunity to discuss their development.

Staff had completed competencies for using a blood analyser for managing blood samples in the clinic.

There were several specialist nurses who held nurse led clinics. During our inspection, there was a nurse specialist Colo-rectal clinic and a nurse specialist haematology clinic running.

Physiotherapy staff told us they had a competency framework. Three staff were completing a Master’s degree module.

**Multidisciplinary working**

The outpatient departments had a range of staff working together as a multidisciplinary team.

Various specialities held multidisciplinary team meetings.

Physiotherapists worked in a range of different clinics including orthopaedic and plastic surgery.

**Seven-day services**

Most outpatient clinics were held Monday to Friday. Weekend and evening clinics had been held to cope with the backlog of patients.

**Health promotion**

There were several health promotion leaflets located throughout the departments.

In the ophthalmology outpatient area, we saw information about organ and tissue donation, promoting cornea donation.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with understood their responsibilities when obtaining consent from patients. We observed staff taking verbal consent from patients before taking bloods in the phlebotomy clinic.

Staff told us that they would obtain advice from the safeguarding team if they had concerns about a patient’s mental capacity to consent.
Staff had access to a consent policy and mental capacity policy.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff compliance with mental capacity act training at the end of June 2018 is shown below, this is not site specific:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>316</td>
<td>318</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Is the service caring?**

**Compassionate care**

We observed staff behaving in a caring manner towards patients, treating them with dignity and respect.

We heard staff introducing themselves to patients. We spoke with 11 patients and all apart from one patient said that the staff introduced themselves and explained their role.

Patients we spoke with spoke positively about staff, they said they were friendly and helpful.

Friends and family test results for June 2018 showed that 97.5% of patients would recommend the service.

All consultations took place in closed rooms, ensuring privacy and dignity.

Chaperones were available and signs were displayed informing patients they could request a chaperone if required.

**Emotional support**

Clinical nurse specialists were available in some clinics to provide additional support.

We observed patients seen with long standing conditions supported emotionally by staff.

In the phlebotomy clinic we observed staff supporting a patient who was very difficult to take blood from, they offered kindness and reassurance.

**Understanding and involvement of patients and those close to them**

Patients we spoke with told us they felt involved in their care and were involved in the decision making. They felt they were given time to ask questions.

Patients we spoke with told us their families had been involved in their appointments and the decisions about their care.

We observed staff in the phlebotomy clinic asking a long-term patient which doctor they would like to see.
Is the service responsive?

Service delivery to meet the needs of local people

We asked eight patients whether they had been offered a choice of appointment date and time or were offered a change of appointment. Five told us they had been offered a choice of appointment or had been able to change an appointment.

Evening and weekend clinics were held in response to demand. The service managed to achieve around 90% of extra clinic requests.

Patients usually had a choice of where they had their outpatient appointment. Clinics for the most common specialities, such as rheumatology, cardiology, respiratory and urology were held across the three hospital sites.

Patients could access shuttle buses between the three sites, these enabled patients travelling from other areas to attend the hospital. Transport was provided for those patients that needed it.

Some of the patients we spoke with told us that the signposting to the department was clear but two told us it was confusing. We found that the signposting to outpatients could be confusing as there were still signs indicating outpatient clinics and fracture clinic were in the accident and emergency department. When we spoke to staff they told us these were old signs and the clinics were no longer in this location.

Dewsbury had a mixed ethnic population and Tuberculosis (TB) specialist clinics had been arranged following an outbreak when people likely to have been affected were called in for screening.

Meeting people’s individual needs

There was a quiet room, which could be used for those patients needing somewhere quieter and more private than the main waiting area. This room had been risk assessed by the prison and was suitable for prisoners to wait in.

Throughout the clinics we saw a leaflet for patients to complete and send to the trust if they had any communication needs. This ensured that any communication needs were highlighted and flagged up on the system. Staff we spoke with told us they knew of patients that required large print letters and they had seen patients attend with these. This ensured that the service was meeting the Accessible Information Standard (2017). The ‘Accessible Information Standard’ – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

VIP passports were used, which gave specific information about an individual’s needs.

Bariatric beds, chairs and wheelchairs were available.

A trust dementia nurse and learning disability nurse were available to provide advice and support to staff. Patients could wait in the quiet room if they found busy environments distressing. Phlebotomists told us that they would ensure two phlebotomists were available to assist with any patient living with learning difficulties or dementia.

We saw that the department had a disabled toilet and a seated weighing scale for those patients that couldn’t stand.

Any additional needs such as the need for a stretcher or a wheelchair were recorded on the system and reception staff would let the nursing staff know.
Staff could access interpreters if required. We heard a staff member asking a patient if they required an interpreter.

Clinics we visited had a range of patient information leaflets, some of these were available in different languages. Patients with vision impairment were given yellow information sheets and offered larger font letters.

**Access and flow**

At our previous inspection, there were concerns with waiting backlogs and referral to treatment times. At this inspection, we found that although there was still a backlog of patients waiting for appointments this had improved and referral to treatment times had also improved, despite an increasing number of referrals.

At our last inspection, the backlog of patients waiting was 19,647, this had reduced to 17,516 in June 2018. There had been a reduction in the number of patient’s waiting more than 35 weeks from 449 in June 2017 to 193 in June 2018. There were no patients waiting over 52 weeks.

Some specialities, such as ophthalmology and trauma and orthopaedics, which had the biggest backlog, had decreased their backlog whilst for others, such as gastroenterology, neurology and rheumatology, it had increased. It was not clear what the reason for the increases were in some services, there was no evidence that increased referrals to the service had an impact on the backlog. Ophthalmology still had the highest backlog but this had reduced from 6942 at our last inspection to 5407 in April 2018. Data received following the inspection showed that this had reduced further still to 5272 by the 25 July 2018.

We saw a waiting list initiative spreadsheet, which had been produced so that extra clinics could be held. This indicated the speciality, how many consultants there would be, rooms needed and the proposed date and time of the clinic. This spreadsheet was then checked by the matron and managers who indicated whether a room and a nurse could be provided for the clinic to take place.

The outpatient efficiency dashboard showed a target of 95% for clinic slot utilisation, between January and March 2018 clinic slot utilisation was at 85.5%.

The service had undertaken several initiatives to try to balance capacity and demand, including increasing internal capacity through some evening and weekend clinics, carrying out an in-depth review of ophthalmology services and increasing the use of alternative providers, for example dermatology patients may be triaged as being suitable to be seen by an independent provider.

The trust had worked closely with the local clinical commissioning group (CCG) to reduce waiting times and improve performance against cancer targets. Summit meetings were held which brought together secondary and primary care along with the CCG to look at the whole pathway.

We asked for evidence of clinical and recovery plans for high risk specialities. We were provided with an ophthalmology service improvement programme and an endoscopy surveillance trajectory briefing. These showed that endoscopy services had planned to clear their backlog by June 2018, but this had not been achieved and at the 22 June 2018 there were still 162 patients waiting. It was not clear from the ophthalmology improvement programme what the trajectory was for clearing the backlog.

At our last inspection, no specialities were above the England average for non-admitted referral to treatment times (RTT) or incomplete pathways RTT and there had been a downward trend in performance. At this inspection, although the trust performance had been worse than the England average overall, figures showed an increasing performance and three specialities were above the England average for non-admitted pathways and five specialities were above the England average for incomplete pathways.
In May 2017, the trust ranked 182 out of 189 nationally for their 18-week performance, in May 2018 this had improved to 130 out of 185.

Data provided by the trust showed that the number of non-admitted breaches, waiting more than 18 weeks had decreased from 3998 in June 2017 to 2459 in June 2018.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From May 2017 to March 2018 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for March 2018 showed 83.9% of this group of patients were treated within 18 weeks versus the England average of 80.8% showing an increase in performance against the England average.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Three specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>91.0%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87.7%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>86.0%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>

15 specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>91.3%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>89.1%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Other</td>
<td>88.5%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>88.0%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>87.0%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>85.4%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>84.5%</td>
<td>87.8%</td>
</tr>
</tbody>
</table>
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance, and has not met the 92% target.

The trust performance has shown a steady increase since April 2017 but as of February 2018 remains below the England average.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, The Mid Yorkshire Hospitals NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Five specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>97.3%</td>
<td>96.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>96.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>92.2%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>89.5%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>84.6%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

12 specialities were below the England average for incomplete pathways RTT (percentage within 18 weeks).
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>88.6%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Other</td>
<td>87.7%</td>
<td>90.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>86.8%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>86.3%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>83.9%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.3%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>82.8%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>81.6%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>77.1%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>73.5%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>71.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>67.9%</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust had performed better than the operational standard for cancer waiting times. Although there had been a slight decline in performance for people waiting less than 62 days for urgent GP referral and they had not met the standard for quarter four of 2017/18, they were still in line with the England average. This was an improvement since the last inspection when the trust had performed worse than the operational standard.

When we spoke with staff about this they told us that they had seen an increased number of referrals linked to public health campaigns. They had recently recruited more staff and were holding weekly breach meetings, looking at those patients who had been waiting over 50 days to try and move forward. Extra clinics were held and root cause analysis done on every breach.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.
Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, The Mid Yorkshire Hospitals NHS Trust

![Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment](image)

(Source: NHS England – Cancer Waits)

Waiting times in the department were variable. Staff we spoke with told us that some clinics had been reformatted to give longer appointment times and they had seen an improvement in patient waiting times.

Did not attend rate

From February 2017 to January 2018,

- The ‘did not attend’ rate for Dewsbury & District Hospital was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, The Mid Yorkshire Hospitals NHS Trust

![Proportion of patients who did not attend appointment](image)

(Source: Hospital Episode Statistics)

Patient feedback had included that they would like an appointment reminder. A texting pilot had been rolled out, where texts were sent to patients to remind them of their appointments.

A pilot was underway in plastic surgery for patient initiated follow up, where an appointment date and time would not be sent but a letter sent asking the patient to call to make an appointment that was convenient for them.
Learning from complaints and concerns

We saw information displayed informing patients how to make a complaint. Leaflets were available for patients which told them how to make a comment, complaint or express their appreciation. The leaflet contained contact details for the complainant to use to submit a complaint, an explanation of what would happen next, and of what to do if the patient remained dissatisfied following the investigation of their complaint.

Summary of complaints

From April 2017 to March 2018 there were 298 complaints about outpatients trustwide. The trust took an average of 29 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 30 days.

Complaints in relation to patient care accounted for 47% of all complaints received and were the largest theme in outpatients.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Although these complaints appear to relate to outpatients, most them were dealt with by the specialities and were not specific to the outpatient department.

The last formal complaint made specifically about the outpatient department was in March 2017.

Staff we spoke with told us that most complaints were informal and were resolved at department level.

Number of compliments made to the trust

From April 2017 to March 2018 there were 115 compliments within outpatients.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The outpatient’s department was part of the division of surgery, access, booking and choice. Access, booking and choice had a deputy director of operations, a patient services manager and a group manager.

Since our last inspection there had been a change in the leadership. A new lead had been appointed for the access, booking and choice directorate and a new outpatient matron had been appointed. The outpatient matron had been in post since September 2017. Prior to this, staff told us they were without a matron for around 18 months.

Vision and strategy

We saw the outpatient mission statement displayed on the wall.

The outpatient service had developed its strategy in line with the trust strategy.

Staff were aware of the trust vision and values.
Culture

All staff we spoke with talked positively about working for the trust.
Staff worked well as a team for the benefit of the patients. Morale was good.

Governance

The division of surgery, access, booking and choice had a clinical governance manager.

There were governance structures in place which ensured that information was fed from operational level up to board level. The access, booking and choice directorate held governance meetings, these reported to the divisional governance meetings, which in turn reported to the quality committee and this reported to the board of directors. Any serious issues could be escalated through these meetings up to board level.

Governance meetings looked at incident reporting and any trends, new guidance and alerts and reviewed the risk register.

Management of risk, issues and performance

Risk registers were reviewed monthly in governance meetings. Risks of 12 or above were referred to the divisional governance meetings. Divisional risk registers were then reviewed at the quality committee meetings.

A risk register was in place for the access, booking and choice directorate.

An outpatient efficiency dashboard had been developed to help specialties view and manage their performance against four key outpatient improvement schemes and associated key performance indicators. This gave information on hospital generated outpatient appointment cancellations under six weeks, did not attend (DNA) rates by specialty, consecutive DNA’s and clinic slot utilisation by specialty.

Joint planned care meetings were held fortnightly with commissioners to monitor performance.

Information management

Electronic requesting software was used for electronic requests for follow up appointments.

Standard operating procedures and process flows were available to support outpatients staff.

The service used the data it had in weekly and monthly performance reports and dashboards, which helped determine priorities.

Engagement

Friends and family test posters were displayed and feedback forms and boxes for the forms to be posted in were available. We heard staff asking patients whether they would mind completing one of the forms.

Staff we spoke with told us they felt the chief executive engaged with staff and that they could contact him if required.
Regular team meetings did not take place due to time constraints but the matron produced a monthly newsletter. Staff spoke positively about this and felt they were engaged with and provided with information.

Engagement with patients was visible with ‘you told us’ ‘we did’ displays. For example, patients had told them that couches and chairs were torn and these had been replaced.

**Learning, continuous improvement and innovation**

A virtual fracture clinic was being developed to reduce the number of inappropriate attendances at fracture clinic, which would potentially improve capacity.
Urgent and emergency care

Facts and data about this service

Pontefract urgent treatment centre (UTC) is located in the Pontefract hospital. The UTC was established in April 2018, prior to this the location provided emergency care services. The service now provides treatment for urgent, non-life-threatening illness or injury 24 hours a day, seven days a week.

The urgent treatment centre is run by GPs and specialist nurses, it offers emergency treatment with and without appointments. Appointments can be booked through the NHS 111 service.

The UTC had a range of illness and injuries it could treat including strains and sprains, cuts and grazes and ear and throat infections amongst others.

The unit would not treat life-threatening injuries and patients attending with these conditions would be transferred to another hospital.

Full urgent and emergency care services are provided at the other two hospital sites

- Dewsbury and District Hospital
- Pinderfields Hospital

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Activity and patient throughput

We reviewed activity data for the unit, this showed that between April and July 2018 the overall emergency care standard performance had been above 97.8%. Across the six weeks prior to the inspection the dashboard showed that average performance against the standard at Pontefract alone was 98.3%.

The same dashboard also showed:

- 894 walk in patient attended the UTC
- 2 ambulance admissions
- 0 handover delays 15/60 mins
- 48.8% time of admission to initial assessment (15 mins)
• 32.2% time to treatment (60 mins)

The average age bands of attendances were:
• 0-9 years - 142 patients
• 10-19 years - 128 patients
• 20-29 years - 155 patients
• 30-39 years - 129 patients
• 40-49 years - 102 patients
• 50-59 years - 100 patients
• 60-69 years - 67 patients
• 70-79 years - 46 patients
• 80-90 years - 25 patients
• 90+ years - 3 patients

Is the service safe?

Mandatory training

At our last inspection in 2017, when the unit was classed as an emergency department none of the staff groups were fully meeting the target standard for training of 95%. At this inspection staff we spoke with said that they had all completed their mandatory training, or had dates for completion booked in.

The trust set a target of 95% for completion of mandatory training.

We reviewed compliance for mandatory training courses from April 2018 to March 2017 for qualified nursing staff and medical staff working in the UTC this showed on the majority of occasions compliance for all training required. Eight out of nine staff had completed ILS training in 2017 (one staff member on maternity leave), in 2018, six staff had already completed the training with three staff having dates for training already booked. Paediatric immediate life support showed that five staff had completed the training in 2017, this improved to 6 staff trained and 3 staff with booked training dates in 2018.

All other mandatory training was completed as part of the MAST training programme and in 2018 seven staff had completed this training, with two requiring dates to be booked. Staff were alerted the need for training via the payroll system.

Safeguarding

At our last inspection in May 2017, when the unit was classed as an emergency department, we did not see compliance with the training targets required for safeguarding training. During this inspection, we saw improved levels of compliance at this inspection, the target level for training had remained the same at 95%. Data we reviewed on-site specifically for staff working at Pontefract UTC, showed that all the staff working at the UTC were trained to the level three standard.

The medical staff at Pontefract UTC were managed by a separate service provider and were not employed by the trust. The trust supplied us with information from this provider which showed that safeguarding training compliance for medical staff was 97% as of July 2018.
At this inspection, the service had systems in place for the identification and management of adults and children at risk of abuse. Staff we spoke with said that they had completed adult and children’s safeguarding as part of their mandatory training. They also said that the trust safeguarding team was accessible and supportive when staff needed advice about safeguarding concerns.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern, and knew how to raise them. Staff we spoke with could provide examples of safeguarding referrals they had made to ensure patients were safe.

The trust had a paediatric liaison team, who reviewed the records of children who had been through the department daily. The purpose was to ensure that any relevant organisations such as GPs, school nurses or health visitors had been informed of the visit and to make sure that no vulnerable children, or incidents had been missed. Any variance from the policy was recorded as an incident and investigated through the incident process.

The triage system included the use of a screening tool, staff used this tool to establish parental responsibility, who attended with the child and whether the child has a social worker.

Information supplied by the trust showed that:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of children attending UTC</th>
<th>Number of children’s social care referrals made</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>1003</td>
<td>2</td>
</tr>
<tr>
<td>May 2018</td>
<td>1213</td>
<td>0</td>
</tr>
<tr>
<td>June 2018</td>
<td>1071</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>Data not available yet</td>
<td>9 to date</td>
</tr>
</tbody>
</table>

The record system in the department routinely showed how many times adults or children had attended the trust emergency departments in the last 12 months. It also had alerts on screen to make staff aware of any special circumstances or concerns relating to the patient.

Safeguarding training included specific training about child sexual exploitation, people trafficking and female genital mutilation (FGM).

Domestic violence information was displayed in both the male and female toilets.

**Cleanliness, infection control and hygiene**

At this inspection, we found the unit was visibly clean and tidy. We reviewed domestic monitoring forms and saw that in June 2018, overall cleanliness in the department was 94%.

The trust had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination and personal protective clothing.

Records we reviewed showed that that eight out of nine staff had completed infection prevention and control training; this data did not include compliance for medical staff as this was held by a private provider.

Following the inspection, the trust provided us with front line ownership audit data, which showed that on the majority of occasions the trust scored 100% for the criteria being measured.

During the inspection, we observed that staff were compliant with hand hygiene policies, including ‘bare below the elbows’ and personal protective clothing policies.

Handwashing advice was clearly displayed and facilities for hand hygiene were available. We observed staff decontaminating their hands appropriately. Staff had access to at the point of use alcohol gel.

We inspected reusable equipment stored on the department, and all items appeared to be visibly clean and ready for use. We observed staff cleaning and disinfecting equipment between patients,
which followed the trust policy. We did not see that staff used a specific label to identify the equipment was clean and ready for use. We reviewed five pieces of reusable clinical equipment and found these to be clean but not labelled.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE). We observed staff using gloves and aprons appropriately.

We saw processes for segregation of waste including clinical waste. Staff could segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure, dated signed and stored of the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

Rooms were available for patients requiring isolation.

**Environment and equipment**

Resuscitation equipment including paediatric and neonatal were available in the department. We checked these and found that they all contained the relevant equipment. However, we found five pieces of equipment we reviewed were out of date; for example, we saw paediatric airways out of date since May 2018 and other specialist resuscitation equipment out of date since February 2018.

The department did not have access to a designated mental health room, they did have access to a quiet area which was where patients with mental health conditions waited if they were supervised by relatives, however this was located out of sight of the nurse’s station. We inspected the room and found that it contained fixings which posed ligature risks to patients. We discussed this with staff working on the unit and they showed us another area opposite the nurse’s station where they would treat patients with mental health conditions, however this area too contained ligature risks. We discussed this with the trust during the inspection and they provided information on actions taken, however we did not receive assurance that the location was suitable for patients with mental health conditions.

The department had a mixed waiting area, located in the main entrance and a specific children’s waiting area, located in the main department. The children’s waiting area had toys and a television available.

The department was separated into different areas for patients to be reviewed. There was no separate paediatric clinical area for patients, however some cubicles had been made into a child friendly environment. However, they were adjacent to cubicles where adult patients were receiving their care. A treatment room was also available where patients could wait for transfer to other emergency departments.

Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of stock rotation.

We looked at five pieces of equipment and found the majority to have been safety tested within the review date.

**Assessing and responding to patient risk**

Following a reconfiguration of acute hospital services at the trust, which was completed in September 2017, emergency and complex care is centralised at Pinderfields Hospital. Dewsbury and District Hospital has a focus on elective and non-complex care and Pontefract on non-complex care and rehabilitation.

As a result, the emergency departments have protocols in place, in agreement with Yorkshire
Ambulance Service (YAS), regarding the patients who can be admitted by ambulance, and no pre-alerts for unwell patients to be seen in the resuscitation room are accepted at Pontefract. Acutely unwell patients are taken to Pinderfields ED by ambulance, but may still self-present to Pontefract UTC. This meant the department received low numbers of patients via ambulance. Staff we spoke with working in the UTC were aware of this protocol, we asked to review the protocol, post the inspection this was supplied, this contained information regarding eligibility and acceptance criteria of ambulance patients to the UTC.

It is a standard for UTCs for patients to be assessed within 15 minutes of arrival. A streaming and triage process was in place in the UTC; however, during the inspection we were concerned that initial streaming was undertaken at the reception desk, by reception staff they streamed patients into red (to be seen by GP’s) and blue chairs (to be seen by ENP’s). Streaming was dependent upon the patient’s clinical presentation staff we spoke with said that “if you could see the injury, it was streamed to blue chair, everything else streamed to red”. They also said that on the other sites lists of conditions/injuries were available for reception staff to use to stream. It is recognised best practice in emergency departments to carry out clinical streaming, however this streaming should be undertaken by a trained clinician as soon as possible following admission, streaming of patients by reception staff did not meet best practice guidance.

All patients were then seen by a registered nurse who triaged the patients and clinically streamed them to the appropriate area, for example nurse practitioner or GP. All registered nurses were trained to triage patients and used a recognised triage tool.

We reviewed ten sets of records for the time of attendance to the time of triage and saw that on the majority of occasions this was within 15 mins

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Attendance time</th>
<th>Triage time</th>
<th>Seen by Dr</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10.14</td>
<td>Not available</td>
<td>10.30</td>
</tr>
<tr>
<td>2</td>
<td>10.14</td>
<td>10.19</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>06.03</td>
<td>06.13</td>
<td>06.30</td>
</tr>
<tr>
<td>4</td>
<td>08.18</td>
<td>08.25</td>
<td>08.27</td>
</tr>
<tr>
<td>5</td>
<td>10.55</td>
<td>Not available</td>
<td>10.58</td>
</tr>
<tr>
<td>6</td>
<td>13.30</td>
<td>Not available</td>
<td>13.31</td>
</tr>
<tr>
<td>7</td>
<td>11.58</td>
<td>12.03</td>
<td>13.10</td>
</tr>
<tr>
<td>8</td>
<td>14.41</td>
<td>15.21</td>
<td>16.41</td>
</tr>
<tr>
<td>9</td>
<td>21.49</td>
<td>22.11</td>
<td>Left without being seen</td>
</tr>
<tr>
<td>10</td>
<td>13.53</td>
<td>14.07</td>
<td>N/A</td>
</tr>
<tr>
<td>11</td>
<td>13.58</td>
<td>14.04</td>
<td>N/A</td>
</tr>
<tr>
<td>12</td>
<td>14.10</td>
<td>14.18</td>
<td>N/A</td>
</tr>
<tr>
<td>13</td>
<td>14.32</td>
<td>14.36</td>
<td>N/A</td>
</tr>
</tbody>
</table>

It is a standard for UTC’s for pre-booked patients (appointments made by 111) to be seen and treated within 30 minutes of their appointment time. Across the six weeks prior to the inspection the dashboard we reviewed showed that the UTC had only received two ambulance admissions and neither resulted in any delay.
The department did not have a designated mental health assessment room, a quiet room they did use was located out of sight of the nurse’s station. This room was not ligature free and did not have access to equipment to summon for help if required. Staff we spoke with also said they used the treatment cubicles opposite the nurse’s station, these too were not ligature free.

We asked to review a mental health risk assessment, this identified short term and long-term actions, there was no dates identified for the long-term actions to be completed this included removal of all ligature risks.

Staff in the department could tell us how they would manage patients in the department with mental health needs. During the inspection, we did not see any patients presenting with mental health issues in the UTC however, one adult had presented in the department recently and staff spoke with us about concerns they had for their own safety and other patient’s safety whilst caring for this patient due to the numbers of staff on duty.

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating; this indicated when a patient may require a higher level of care and transfer from the unit. Following the inspection, we asked to review information on how the service reviews patient outcomes, including NEWS and PAWS audits. We were not supplied with these.

The unit had access to an on-site resuscitation team, this included an on-site anaesthetist.

We spoke with one patient who arrived by ambulance reported they had been seen straight away.

Paediatric patients who were unwell, were transferred to Pinderfields hospitals for further assessment. Information supplied by the trust showed that out of 3287 paediatric patients seen at the UTC in April to June 2018, 77 patients had been referred to Pinderfields with 75 children been admitted to hospital.

<table>
<thead>
<tr>
<th>UTC children referred to PGH paediatrics</th>
<th>Number of children referred</th>
<th>Number of children admitted to hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>33</td>
<td>32</td>
</tr>
<tr>
<td>May 2018</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>June 2018</td>
<td>23</td>
<td>23</td>
</tr>
</tbody>
</table>

The above table suggests appropriate decision-making took place when deciding to transfer children for further assessment and treatment from the UTC.

Staff we spoke with said that they could access a specialist stroke responder and they arranged for patients to be transferred to Pinderfields.

**Nurse staffing**

At the 2017 inspection, we said that the trust must ensure that there were at all times sufficient number (including junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients’ dependency levels.

The department had determined what number of nursing staff was required on each shift to maintain safety of patients. Planned staffing for the dayshift was two registered nurses, two emergency nurse practitioners (ENP), and one health care assistant. Planned staffing for the night shift was one registered nurse and no health care assistants.
On the day of the inspection, we saw that 2 registered nurses were on duty for the day shift and one registered nurse was planned for overnight. We saw that registered nurses were on duty:

- One band 6 7am -7:30pm (Monday -Sunday)
- One (band 7, Monday- Friday), (Band 5 weekends)10am-6pm
- One (band 6) 7pm to 7.30 am (Monday -Sunday)

Health care assistants were on duty 1pm to 12midnight (Monday -Sunday).

Two further Emergency Nurse Practitioners were available 8am- 8.30pm and 10am to 22.30pm (Monday -Sunday).

We reviewed duty rotas over the last three months, and examined 42 shifts. Data we reviewed showed that all areas were staffed at planned levels. However, we were concerned that the current planned number included the unit manager, daily 10-6 (Mon-Fri) and this affected the amount of leadership and support they could offer to staff. We were also concerned that only one registered nurse was planned on duty on all of the 42 night shifts we reviewed.

The staffing levels had been planned for first three months of opening the unit and were due for reviewing in July 2018, at the time of the inspection the unit manager nor the head of clinical service was aware of the date of this review, we saw that staffing rotas had already been planned for the following two months which remained the same.

When only one registered nurse was on duty, there was a standard operating procedure to use additional staff from the inpatient wards to help in the UTC, staff we spoke with said that they had developed the SOP following the unit opening as one was not available, they also said that on most occasions the inpatient wards at Pontefract did not have additional staff to assist in the UTC. Staff we spoke with provided examples of when 25 patients were in the UTC at 11pm and only one registered nurse was on duty from 12pm.

All staff we spoke with highlighted concerns about the staffing levels on the unit.

At the 2017 inspection, we highlighted that the department was not meeting paediatric nurse staffing levels, these state that there should be 24-hour children’s nurse presence in the department. Since the inspection the unit had changed from an emergency department to a UTC, but they still accepted attendance from children. At the time of inspection the SOP stated that there would be a senior nurse with paediatric immediate life support training on every shift. A rota ‘rule’ requiring such a trained nurse on each shift on e-rostering supported this. The SOP also stated that all medical staff would be paediatric immediate life support trained. During the inspection, children were in the department for treatment, this meant that the Intercollegiate Emergency Standard to have sufficient RSCNs to provide one per shift was not met. No registered nurses or ENPs had completed any further university modules specifically focusing on paediatrics. During the inspection, we saw a number of paediatric attendances and data we reviewed showed that 3287 children had been seen in the department since April 2018 to July 2018.

**Medical staffing**

Medical staffing was provided by GP on a 24 hour basis, seven days a week. They operated on a three-shift basis 8am to 6pm, 6pm to 12 midnight and 11pm to 8am. GP’s employed at the unit were employed by a private company and not by the trust.

General practitioners were supported by urgent care practitioners who worked 9am to 9.30pm or 10am to 10.30pm and a 6pm to 12 midnight. At the time of the inspection, all the urgent care practitioner’s shifts were filled by locum staff.
Records

Paper and electronic records were used in the UTC. Written records were scanned into the electronic record system daily. We reviewed 23 sets of patients’ records and found completion of documentation to be in line with professional standards, for example all writing was legible and all entries were dated and timed. Records were stored securely when not in use and were only accessible to appropriate people. Individual care records were written and managed in a way that kept patients safe. The care records we reviewed showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Previous attendance in any of the trusts emergency departments was clearly identified and allergies and clinical observations were completed.

Medicines

We saw medicines including controlled drugs were stored correctly with access restricted to authorised staff, they were checked in line with the policy and there were no discrepancies in controlled drug registers. Controlled drugs were audited by the nurse in charge of the unit daily. We did see evidence of stock rotation and regular checking by pharmacy staff. Fridge temperatures were recorded centrally and monitored by the pharmacy department. We also saw action recorded if the temperatures were not within expected ranges. Pharmacy services were available seven days a week, with an on-call service available out of hours and on a Sunday. As only one registered nurse was on duty overnight, if medicines needed a second verification check, the medical staff were asked to assist with this, or staff from other areas were requested. Urgent care practitioners in the department could not prescribe medicines, medicines if required were prescribed by the GP. During the inspection, we noted that paper copies of patient group directions (PGD) for various medicines including ibuprofen, paracetamol, co-codamol etc had not been reviewed since 2014 and had not been signed by all staff working in the unit. A PGD is written instruction, which allows the supply and/or administration of prescription only medicines to a group of patients without individual prescriptions. Certain legal requirements are required including the start and end date of the PGD, a signature of doctor and a pharmacist. We highlighted this finding at the time of the inspection.

Incidents

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Since the opening of the unit no incidents classified as never events had been declared in the department.

In accordance with the Serious Incident Framework 2015, none of the serious incidents reported in urgent and emergency care related to care provided at the UTC.

The unit manager we spoke with said that if a serious incident occurred they would be involved in the root cause analysis process. We reviewed incidents reported by staff since the opening of the unit April 2018, we saw that 11 incidents had been reported, information supplied by the trust showed:
The service had systems in place for reporting, monitoring and learning from incidents. The trust had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The trust also had an electronic reporting system in place and staff we spoke with could describe how they would report incidents. Staff we spoke with said that there was a “reluctance” to report incidents due to poor feedback being received about reporting. Staff we spoke with did highlight awareness of incident forms completed by staff, highlighting staffing levels at night. Staff we spoke with were not aware of the top three incidents for their area. Staff did not always receive feedback when incidents occurred for example missed fracture procedures, ENP’s were not always informed that they had missed a fracture, this does not provide assurance of learning and development. Staff we spoke with said that the trust shared learning from incidents by staff meetings, individual discussion and via the intranet. Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain examples of when they would use this. Duty of candour requirements were detailed in all the reports we reviewed. The majority of staff we spoke with were aware of the duty of candour regulations, they could provide us with examples of when they would use this such as missed fractures and the need to be open and honest with patients. The directorate held specific mortality and morbidity meetings for the emergency departments including the UTC. The assistant clinical director said that all ED deaths were reviewed at these meeting and learning was identified and shared with the departments and organisation. We asked to review minutes from these meetings we were supplied with these, however they had very limited assurance on incidents occurring within the UTC.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure...
ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Departmental policies were based on NICE (National Institute for Health and Clinical Excellence) and Royal College guidelines. The department used an online resource to check the most up to date guidance was being used and messages could be shared with all medical staff via this system. Staff were aware of policies and procedures and knew where to find them. However, when we checked the policies on the trust intranet we found some of them to be out of date. We saw at Pinderfields ED that staff had access to policies and procedures through clinical emergency medicine (CEM) books, but saw no evidence of this being used at Pontefract. At the last inspection, we had concerns over the lack of participation in sepsis audits, at this inspection we were not supplied with any audits to review, a standard operating procedure was available which indicated treatment would be commenced at the UTC and then the patient transferred to Pinderfields hospital. We asked staff what clinical audit activity they participated in this information was very limited, for example pain audits, health and safety audits and mattresses audits because of this the service did not have assurance that patients who attended the UTC were receiving care and treatment in line with best practice guidelines and pathways. We were only supplied with the pain audit to review. This provided very limited assurance of patient outcomes, Following the inspection the service confirmed that the matron’s assurance audits were not being completed, because of this the service did not have assurance that patients who attended the UTC were receiving care and treatment in line with best practice guidelines and pathways. The head of clinical service spoke with us about quality improving projects being undertaken in the departments, however these projects were not occurring in the UTC.

Nutrition and hydration

Staff we spoke with said that patients had access to food if required, access to fresh water was available at the nurse’s station.

Patients we spoke with said that they had been offered a drink. None of the patients in the department or records we reviewed required fluid balance charts.

Pain relief

Records we reviewed showed that patients had been offered pain relief. Staff we spoke with said that patients who attended the department were offered pain relief. We did not observe staff using pain scoring tools to assess patients’ levels of pain; however, records we reviewed, showed that staff did initially use these during triage and treatment, and staff we spoke with said they used a specific paediatric one with children.

Patient outcomes

We asked to review performance data from the trust used to measure patient outcomes, following
the inspection, the trust informed us that they currently audit, prescribing, blood results, children and young people attendances and patients pain.

We asked to review clinical audit data, data we were supplied with pain audits, these audits showed that patients had their pain levels assessed regularly and received pain medicines if required.

**Competent staff**

Senior staff we spoke with said that they had 360-degree appraisals to ensure that information was gathered from a wide variety of staff on their performance. Other members of staff said that they had all received their appraisals.

Senior staff we spoke with said that they had developed extended roles for nursing staff. These were nursing staff with extended skills to support patients. For example; advanced nurse practitioners staff had to complete additional training and competence qualifications to allow them to undertake these roles.

Staff we spoke with said that if they trained in a new skill, they had to be signed off 10 times, prior to being signed off as competent. During the inspection, we were not able to see any competence forms to confirm this.

Registered staff we spoke with that they had been supported through revalidation by the trust.

**Multidisciplinary working**

There was evidence of effective multi-disciplinary team working, including seeking advice and joint decision making about patients across the emergency departments.

Staff had access to 24-hour telephone access to mental health liaison staff.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.

**Seven-day services**

The UTC offered a seven-day service staffed 24 hours a day.

Staff could access support from consultants based at one of the other sites throughout the 24-hour period.

The department was staffed by an emergency nurse practitioner, urgent care practitioner, staff nurse, health care assistant and general practitioners.

There was access to diagnostic blood tests, some were performed onsite and others had to be sent off site for testing.

Radiology tests such as X-rays were carried out as required and there was 24-hour access to radiology services. Patients needing other radiological investigations, such computerised tomography (CT) or magnetic resonance imaging (MRI) scans were transferred to Pinderfields.

**Health promotion**

Health promotion information was available in the UTC. This included display boards and information leaflets. We saw information smoking cessation, healthy eating, drugs, alcohol and housing needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients had consented to treatment in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

The Mental Capacity Act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, were someone is
judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests.

We spoke with six members of staff across the department. All the staff knew what to do if a patient lacked capacity. Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for a patient who lacked capacity.

Data we reviewed on-site showed that at the time of the inspection (May 2018), level 1 Mental Capacity Act (MCA) training compliance was 87%, level 2 88%.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person’s best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLS). DoLS can only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.

Staff we spoke with said they had access to mental health referral pathways and they would use these with any patients they had concerns about.

Staff we spoke with were aware of Fraser guidelines relating to decisions made by children and young people.

### Is the service caring?

#### Compassionate care

During the inspection, we spoke with three patients and one relative who were happy with the care and treatment they had received.

Patients we spoke with said that staff treated them with dignity and respect.

Staff we spoke with said that they delivered care and treatment at a level acceptable to them.

We observed staff closing curtains and doors whilst delivering personal care.

The trust’s urgent and emergency care Friends and Family Test response rate was better than the England average July 2018, 18% trust performance compared to 13% England average.

In July 2018 the trust performance was 95% compared to the England average performance of 84.3%.

#### Emotional support

We saw that the unit manager was visible, and patients and relatives could speak with them.

We heard a conversation between a patient and nursing staff and heard nursing staff providing comfort and support.

Patients we spoke with said that staff were available to talk to them as required.

A multi-faith chaplaincy service was available for patients.

Staff we spoke with providing examples of how they would support distressed patients and relatives.

Staff could refer patients who presented with alcohol or drug problems to support services.

#### Understanding and involvement of patients and those close to them

A range of information leaflets and advice posters were available. These included discharge information, specialist services and general advice about their care and treatment.

Patients we spoke with said that medical staff took time to explain their care and the risks and benefits of treatment.

Patients we spoke with said that they were aware of their plans of care and they had been given the time for questions and felt listened too.

Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.
Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.
A separate room was available for breaking bad news, however due to the nature of the unit, staff we spoke with said that this area was very rarely used for this purpose.

Is the service responsive?

Service delivery to meet the needs of local people

The trust had decided following internal and external consultation to open the urgent treatment centre.
Patients requiring enhanced care or treatment were transferred to Pinderfields hospital.
The service did not accept the majority of ambulance patients, these would be directly taken to Pinderfields hospital.
The directorate had collaborative working with commissioners and the health overview and scrutiny committee prior to making the changes to the UTC.

Meeting people’s individual needs

Patients who attended the department who were known to be living with dementia or learning disabilities were flagged on the computer system. The VIP scheme was used to identify and support patients with learning disabilities; this was a system used to ensure staff were aware of important patient information and requirements. Patients living with dementia were identified by a butterfly symbol, and a ‘forget-me-not’ sticker was added to their notes to alert staff that extra support may be needed. The trust employed liaison nurses for learning disabilities and dementia, and staff could refer to them for advice or additional support for patients.

We did not see any specific ‘dementia friendly’ cubicles in the UTC, we also did not see that any distraction aids were available for use by patients to help minimise agitation and anxiety. Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

Translation services were available for patients whose first language was not English. Staff we spoke with knew how to access these services. Staff we spoke with said this service was responsive.

Patients were provided with information leaflets on topics such as head injury, treatment for sprains and strains and minor illness. The leaflets were in English and staff informed us that patient advice leaflets could be requested in other languages and formats, including a ‘read aloud’ version. We were not made aware of any other communication aids available, and it was not apparent that patient flagging occurred for those with communication needs.

The departments was accessible for patients with limited mobility and people who use a wheelchair.

Whilst waiting in the unit patients did have access to WIFI via a code that was shared with them.

Access and flow

The emergency care standard is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the department. We asked to review performance data from the trust, data we reviewed showed that across the six weeks prior to the inspection, between April and July 2018 the overall emergency care standard performance had been above 98.3% for the UTC, better than the England average performance of 85%.

The royal college of emergency medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more that one hour. Data we reviewed April to July 2018 for all three emergency departments showed that they did not meet this standard, with a median average time to intervention of 1 hour 21 minutes and a time to diagnosis of 1hr 23 minutes. We were supplied with data to show performance six weeks prior to the inspection, this showed that the UTC only meet this standard on 32.2% of occasions.

It is a standard for emergency patients to be assessed within 15 minutes of arrival, information we reviewed April to July 2018 for all three emergency departments showed that they meet this
standard, with a median average time to triage of 13 minutes. We were supplied with data to show performance six weeks prior to the inspection, this showed that the UTC only meet this standard on 48.8% of occasions.

Information we reviewed over the same time period also showed that the average median total time patients spent in the emergency departments was 1 hour and 32 minutes. We were not supplied with any data for the UTC alone.

We were supplied with data showing the number of patients that left the emergency departments before being seen for treatment this showed that 4.1% of patients left without being seen this was worse than the England average of 3.3%. We were not supplied with any data for the UTC alone.

At this inspection, the accepted patients admitted via ambulance, however staff we spoke with said that they had agreement with the ambulance service to call the unit first to ensure that they would accept the patient. Medically unstable or unwell patients were not accepted and were taken to Pinderfields.

Patients were able via the NHS 111 service to make appointments overnight for medical reviews via a GP.

**Learning from complaints and concerns**

The trust had a process that addressed both formal and informal complaints that were raised by patients or relatives.

We saw information displayed in the UTC about how to complain or raise a concern. Staff we spoke with could describe how they would respond to a compliant or a concern was raised.

Since the unit had opened as a UTC, they had only received two complaints.

Staff we spoke with said that themes and trends of complaints were shared with staff at ward meetings and individual conversations. We reviewed meeting minutes from monthly emergency medicine speciality governance group meetings, which reported to the clinical governance group. We saw that complaints were routinely discussed, along with lessons learned and actions to be taken.

We discussed with staff a recent complaint, staff were able to discuss with us themes from this complaint and changes in practice as a result of this complaint for example improved use of pain scores in paediatric patients.

**Is the service well-led?**

**Leadership**

We found that the unit manager was knowledgeable and professional. They appeared visible and approachable for junior members of staff they supported. The unit manager was not allocated dedicated time for management and support of staff, and was expected to triage, assess and treat patients whilst undertaking unit co-ordinator role. This meant that unit manager had to prioritise work to enable patient care not to be compromised; this often led to them working additional hours or working in their free time to complete management tasks.

All staff we spoke with were complementary about the recent board changes and how this had improved the culture and communication in the trust.

Staff we spoke with said the senior management team were supportive, but not all the SMT were visible on the unit.

**Vision and strategy**
The service had recently been re-configured to meet the demands of the service. Staff we spoke with were aware of the strategy for the UTC, however we did not see the vision or strategy documented within the unit. This was supplied post the inspection and aligned with what staff told us about the vision and strategy, however it didn’t have any publication dates or version control attached to the document. Staff we spoke with also highlighted concerns that the service would be sold to a private contract. This led to some of them not feeling safe in their roles.

**Culture**

Staff we talked with said they felt valued by their patients, colleagues, unit leaders, however they also said that they felt “forgotten about by the rest of the emergency departments and separate to the main departments”

They did say that the CEO had been to visit them and discussed the unit with the staff, staff were grateful for this opportunity.

They said that morale was variable due to the staffing issues within the unit.

The senior management team were proud of staff working within the directorate and their resilience during ‘winter pressures. They said that morale was improving.

**Governance**

The UTC was part of the division of medicine. The directorate had clear governance structures. Each department had an assistant head of nursing, a head of clinical service and an assistant director of operations.

Separate emergency governance meetings were held within the department and the head of clinical service said that issues were escalated to the divisional governance meetings and then to the quality committee and then to the board. Meetings involved all three sites, however due to the staffing levels on the Pontefract site, and the unit manager being rostered for clinical duties staff from Pontefract were rarely able to attend, we requested to review minutes from governance meetings, we were supplied brief notes to review, however these did not include detailed discussion as such we currently have low-levels of assurance against safety performance, from board to ward.

Information we reviewed from the trust showed that the service that the trust did not have robust governance procedures in relation to monitoring of the private GP contract, the trust did not hold the information on the current level of DBS compliance or training compliance for the GP.

**Management of risk, issues and performance**

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

Staff we spoke with were clear about the risks within the department. Senior staff within the directorate highlighted their highest risks, they identified staffing, acquisition of pressure damage and falls. Risk assessments had been carried out but we were not able on site to review specific risk registers for the department, the unit manager confirmed they had not recently seen a copy of the unit or departments risk register. Following the inspection, we reviewed a risk register for the unit this had three risks identified these were two rated as minor risks and one rated as negligible risks following identification of mitigating actions. All three risks were added in April 2018. None of these risks identified by staff as risks for the unit such as staffing levels were identified on the risk register, neither were the risks to mental health patients from ligatures in the department.

Staffing levels at Pontefract was highlighted as a top risk for the unit from staff we spoke with, the senior management team was aware of the risks and had identified mitigating actions, for example requesting assistance from other areas at Pontefract, however staff we spoke with did not feel that this reduced the risks of incidents occurring due to the staffing levels of the other units. Staff we spoke with highlighted a recent incident were overnight when only two staff (one nurse, one doctor) were on duty and a patient had been abusive to staff, threatened staff and staff felt vulnerable as a result.
We requested to review minutes of meetings where risk was discussed, we were supplied with brief notes, these provided limited assurance of discussion and escalation of risk. The head of clinical services said that risk registers were reviewed monthly and key messages were shared via a “risky business” newsletter.

The department and senior management team were aware of the risks of ligature in the areas used for reviewing patients with mental health conditions, however there were no dates identified for long-term actions to be completed by, and a management plan to meet the risks was not available. Following the inspection, a multi-disciplinary task and finish group was convened to review high risk service departments including the urgent care departments to ensure the risks were assessed and management plans were in place to meet them.

The directorate had moved with pace to implement the urgent treatment centre, however data we reviewed did not provide assurance of effective and consistent procedures within the department. We did not receive assurance of consistent performance or patient outcomes, including clinical audit information, the service did not have assurance that patients who attended the UTC were consistently receiving care and treatment in line with best practice guidelines and pathways.

Staff had access to personal alarms and access to the security team had been increased recently because of staff safety concerns overnight.

Information management

Information provided by the trust, showed that 79% of medical staff and 74% of nursing staff had completed information governance training. Compliance rates were worse than the trust’s target level of training of 95%.

We did not have any concerns during the inspection about the security of patient records. Computers were available on the unit. During the inspection, all computers were locked securely when not in use.

We did have concerns during the inspection, that as reception staff worked across all sites, they could book patients on the computer system accidentally to the wrong site, staff we spoke with said that this had happened on occasions, this had been highlighted to them by staff in the other departments when they called for that patient or reception staff spotted that the patient was still waiting.

Engagement

During the inspection we saw “you said we did” display boards these showed changes of practice in relation to patient feedback for example; patients had said that they thought the unit had not enough staff.

Staff we spoke with said that changes in practice had been implemented because of patient feedback, these included providing more information for patients waiting.

The emergency departments had introduced a closed social media group to improve communication of the ward, staff we spoke with said that this helped to share key messages.

The unit had developed a staff comments and suggestions book to improve communication and engagement.

Learning, continuous improvement and innovation

The trust held a celebrating excellence award ceremony, the emergency department at Dewsbury had been highly commended for development of a course to help staff learn and develop their resuscitation skills and care for deteriorating patients.
Medical care (including older people’s care)

Facts and data about this service

There are 693 medical inpatient beds located across three sites and 26 wards/units.

A site breakdown can be found below:

- Pinderfields Hospital: 494 beds are located within 19 wards/units
- Dewsbury and District Hospital: 157 beds are located within six wards/units
- Pontefract Hospital: 42 beds are located within one ward/unit

(Source: Routine Provider Information Request – Sites tab)

The trust flow pathway sees patients transfer out to Dewsbury and District Hospital and Pontefract Hospital once patients are deemed medically stable. However, there is direct access to a frailty unit on the Dewsbury and District Hospital site for the benefit of the local population. The trust currently runs emergency ambulatory care services from both Pinderfields Hospital and Dewsbury and District Hospital.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 71,024 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 33,778 (47.6%), 786 (1.1%) were elective, and the remaining 36,460 (51.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 17,571
- Gastroenterology: 10,966
- Geriatric medicine: 9,183

(Source: Hospital Episode Statistics)

Medical care at Pontefract Hospital was provided on a 42 bedded medical and stroke rehabilitation unit (PMSRU). Care was provided in two sections which were divided by a small corridor and two sets of locked doors. One section had 30 beds (five x four bedded bays and 10 side rooms) and provided 18 stroke rehabilitation beds and 12 beds for people recovering from a fractured neck of femur.

The second section had 12 beds (two x five bedded bays and two side rooms) and provided step down care for medical patients.
Is the service safe?

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed their training. Staff were required to complete core and role specific mandatory training in topic areas such as health and safety, infection control, manual handling and information governance.

The ward manager was able to tell us what the current compliance levels were for the ward and they had access to individual reports for the staff they managed.

Staff we spoke with said they were able to access training sessions and could attend a full day of mandatory and statutory training which covered several topics.

Ward managers told us that staff were not able to progress to the next pay increment if they were not up to date with their core mandatory training.

**Mandatory training completion rates**

The trust set a target of 95% for completion of core mandatory training and 85% for completion of role specific mandatory training.

The ward dashboard showed that mandatory training levels on the unit for June 2018 were 85% for core training and 70% for role specific training. Both were less than the trust target.

**Trust level**

Information provided by the trust on 30 June 2018 showed that the overall compliance rates with core mandatory training for staff working in medical care services was 89% which did not meet the trust target of 95%.

For role specific training, overall compliance rates were 76% which did not meet the trust target of 85%.

**Core MAST Compliance (target 95%)**

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<tr>
<th>CORE SUBJECTS</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
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<td>LOCAL</td>
<td>Diversity Awareness - Once in Employment</td>
<td>59</td>
<td>1538</td>
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<td>Infection Control - Every 2 Years</td>
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<td>1175</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Health and Safety Level 1 - 3 Years</td>
<td>92</td>
<td>1505</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>416</td>
<td>1181</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>109</td>
<td>1488</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>96</td>
<td>1501</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1601</td>
<td>12772</td>
<td>14373</td>
<td>89%</td>
</tr>
</tbody>
</table>

**Role Specific Compliance (target 85%)**
Safeguarding

Staff had a good knowledge and understanding of the trusts safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff knew how to contact the safeguarding team for advice and had access to the team’s details on the intranet. Information on safeguarding with flowcharts for staff to follow, were also available on the intranet.

Safeguarding training completion rates

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module. Senior nursing staff on the unit told us that safeguarding training compliance was at approximately 85%.

Trust level

The trust provided a breakdown of compliance on 30 June 2018 for safeguarding training modules for staff working in medical care.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>1501</td>
<td>1597</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>1488</td>
<td>1597</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>1045</td>
<td>1267</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>1021</td>
<td>1256</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 3 additional)</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
For staff in medical care services the compliance target was not met, however it was very close to the target in four out the five training modules.

(Source: Additional Data Request ALL2)

Cleanliness, infection control and hygiene

Hand sanitisation gel was available immediately adjacent to the entrance to the ward, on the corridor outside the ward, and directly outside each bay or room. We noted that on at least 14 occasions staff entered or exited the ward and did not use hand gel. Additionally, a nurse taking blood pressures did not use gel between attending to patients.

Surfaces and floors appeared visibly clean. We observed an ‘I am Clean’ sticker on a noticeboard at the entrance to the unit dated 10 November 2015. This noticeboard was visibly dusty.

Surface disinfectant wipes and personal protective equipment were available outside all patient rooms. We observed nursing staff wearing an apron and gloves when carrying out direct patient care. Handwashing facilities and hand gel were available in each bay and side-room. We saw staff washing their hands and they adhered to the trust policy of bare below the elbows.

In the 12 bedded unit, we found cleaning substances in a lockable cupboard in the pantry. The pantry itself was not lockable, and the cupboard had not been locked. This was the similar in the 30 bedded unit where we found the pantry door was not locked and the cupboard was not lockable. This posed a risk to patients. We brought this to the attention of staff on the ward during our visit and this was rectified.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door.

Infection control audits (FLO audits) were carried out monthly and the results were shared with the ward manager. The unit dashboard showed that monthly audit scores for January to June 2018 ranged between 96% and 100%

We saw appropriate segregation of clinical waste and disposal of sharps. Sharps bins were correctly assembled dated and signed with a temporary closure in place.

Staff were required to attend infection control training as part of their mandatory training. Compliance for the Division of Medicine was 83% the end of June 2018. In addition relevant staff received aseptic non touch technique training (ANTT).

Red aprons were available for staff to wear during medication rounds. This was to limit interruptions and therefore medication errors. However, we did not see staff wearing the aprons during our inspection on the unit.

Environment and equipment

Although this was classed as one unit, it was two distinct areas separated by locked doors and a corridor. There was a 30 bedded area which consisted of five bays of four patients and 10 individual cubicles and a 12 bedded area with two bays of five beds and two side rooms.

The unit was modern and clean, bright and uncluttered. The main entrance to the 30 bedded area was not well lit, and the environment was not dementia friendly. There were no contrasting walls and flooring. We did not see any specific adjustments in the environment for patients with dementia.
There was a room for multidisciplinary team meetings but this was cluttered and equipment was stored in this area. A large whiteboard in the room was used for board rounds, and therefore contained sensitive personal patient information. When not in use it was covered by with a sheet to maintain confidentiality. However, we saw on one occasion it had been left uncovered and the door had been left open.

The assisted bathroom was also used as an overflow store for equipment and staff informed us that it was only used at weekends.

The ward incorporated a large day room. During our visit we saw one family watching TV, and we did not see any patients using this area.

During our second visit to the unit, a door to the 30 bedded area was left open for at least half an hour. At 9.30am we noted a door to the 12 bedded area was propped open using spoons. We were told that the spoons had been placed there by night staff. As there were a high number of patients with dementia resident during our visit, this posed a risk of patients absconding from the ward.

A store cupboard in the 12 bedded unit was propped open with a blood pressure monitor (despite a notice on the door requesting that it is kept locked) which gave patients full access to the equipment store.

There were two emergency resuscitation trolleys available for use, one in the 30 bedded area and a second in the 12 bed area, both had been checked daily by staff. One of the trolleys was visibly dusty. All equipment and consumables were in date. One single use item was in an open packet and this was given to ward manager for replacement. The trolleys were unlocked for quick access; staff told us this had been risk assessed and was trust policy.

The equipment we checked was in good working order and had been safety tested and checked according to manufacturer’s recommendations. This included hoists, blood pressure monitors and chair scales. Some equipment had been labelled with ‘I am clean’ stickers, with the date the equipment was last cleaned. However the use of these was inconsistent and some of the stickers were dated in May 2018.

Equipment for the management and prevention of pressure ulcers was available such as specialist mattresses and cushions.

### Assessing and responding to patient risk

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. Nursing staff recorded patient observations and entered them onto a hand held electronic clinical record system, which calculated the patient’s NEWS. The electronic system alerted nursing staff if the patient’s NEWS changed and what action needed to be taken. The ward manager informed us that they had never had to call for an emergency ambulance. If necessary, they could transfer a patient back to Pinderfields. Patients requiring a percutaneous endoscopic gastronomy (PEG) tube fitting had to be transferred back to Pinderfields as that service was not available at Pontefract.

Compliance with staff carrying out patient observations on time was measured and reported on the ward dashboard. The results were colour rated depending on the score. Results for the unit from October 2017 to June 2018 showed a rating of amber (75% - 85%) for six months and green (above 85%) for three.

The trust audited the effective use of NEWS and escalation of deteriorating patients. We saw the report for September 2017 and noted this had an appropriate action plan for areas which required improvement.
Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk.

We were told that risk assessments for falls, pressure damage and nutrition were updated weekly. The Trust had introduced a process were staff were encouraged to reassess all patients for nutritional risk on Monday, pressure risk on Wednesday and falls risk on Friday. However, we did not see clear evidence in the patient notes we looked at that falls and pressure ulcer risks were reassessed weekly.

Patient risk was discussed at the daily board round. The ward manager informed us that the health care assistants attended the very start of this meeting to obtain information on patients at risk of falls, pressure ulcers and those with specific nutritional needs.

The division recognised that patient falls was a major risk to patient safety and this was included on the risk register. A corporate falls work stream was in place to reduce the number of falls with harm. The work stream was led by a dedicated falls lead.

Measures were in place to minimise the risk of patient falls. A falls bundle was put in place which included the provision of red anti-slip socks, correct walking aids the use of sensor mats. Patients at the highest risk of falling were nursed in Bay 10 to allow close observation. Safety support staff were available to provide one to one support to patients identified with a high risk of falling. We saw a health care assistant closely monitoring two patients in the 12 bedded area of the unit.

The unit kept a log of falls, and plotted these on a ward plan so staff could see at a glance which areas patients had fallen in. Falls were recorded on 30 May, 8 June, 17 June, 29 June, 30 June and 1 July, an average of just over one per week. A patient fell on the day we visited (3 July 2018) and a member of staff was observed seeking assistance from colleagues to help the patient up from the floor. When we returned on 6 July 2018 this fall had not been plotted on the ward plan. Staff told us that approximately 90% of the patients on the ward were at risk of a fall.

A new pressure ulcer risk assessment tool and care plan had been implemented. Measures were put in place for those deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments. Staff referred patients to the tissue viability specialist nurse if they needed advice on how to manage a high risk patient. Work was ongoing to reduce patients experiencing pressure damage. The trust was rolling out ‘react to red’ face to face training for all health care assistants as part of pressure damage improvement work. The tissue viability nurse was providing training to staff to ensure that pressure ulcers were categorised correctly.

The division held monthly pressure ulcer quality meetings which included reviews of recent investigation reports and lessons learnt.

**Nurse staffing**

We had concerns about nurse staffing levels on the unit.

<table>
<thead>
<tr>
<th>Planned staffing levels for the PMSRU</th>
<th>Actual staffing levels on 3 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day</strong></td>
<td>3 RNs + 5 HCAs</td>
</tr>
<tr>
<td>5 RNs + 6 HCAs</td>
<td>One RN left at 3pm leaving 2 on duty</td>
</tr>
<tr>
<td><strong>Night</strong></td>
<td>4 RNs + 5 HCAs</td>
</tr>
<tr>
<td>4 RNs + 5 HCA</td>
<td></td>
</tr>
</tbody>
</table>
Planned staffing for the unit was 5 registered nurses and 6 health care assistants. The actual staffing on 3 July 2018 was 3 nurses and 5 health care assistants. The ward manager was included in the numbers that day until she left at 3pm leaving only two nurses to care for 42 patients from 3pm until the night staff came on duty. There was also a discharge liaison nurse on the unit who was not included in ward staffing numbers.

The ward manager explained that understaffing was a constant issue and that this has been appropriately escalated to the Assistant Director of Nursing & Quality. They informed us that sometimes nursing staff were taken from the unit to fill staff shortages at Pinderfields. Their feeling was that Pinderfields was always the priority, not Pontefract. A therapist we spoke with also commented that the unit felt a bit forgotten and Pinderfields was always the priority.

Day shift fill rates for nurses during the period October 2017 to June 2018 were consistently under 85% with the lowest being in March 2018 at 68.7%. We reviewed nurse staff levels for the previous three months and found there was one day shift with only two nurses on duty, 32 day shifts with three nurses on duty and 14 night shifts with three nurses on duty.

Nursing staff told us that they formed part of the Cardiac Arrest Team for the site, and as such one nurse was required to attend any ‘2222’ (emergency crash calls) as a matter of priority. They told us that due to poor staffing levels, they were sometimes late in responding, or could not respond at all. On the day we visited, there was only one nurse staffing the 12 bedded unit and a second nurse on the 30 bedded unit. Neither could leave their units to respond to a crash call.

Therapy staff we spoke to told us that as the ward was often short of nursing staff so they assisted with washing, dressing and mobilising patients as required. The discharge liaison nurse told us they provided cover for nurses to enable them to take breaks but that this was not really their role.

On our second visit to the ward, we observed that in one of the bays, a health care assistant was monitoring four patients at high risk of a fall. The assistant spent five minutes behind a curtain attending to one patient. There were no other members of staff in the bay and the other three patients were unattended during this time.

During our second visit to the ward, there were two nurses on duty supported by health care assistants. One nurse was in the 30 bedded area and the other nurse was in the 12 bedded area. We saw the nurse from the 12 bedded area enter the 30 bedded area to have a drug checked by their colleague. They were both in the larger unit for approximately five minutes, leaving only non-nursing staff in the other area. When questioned, staff told us that this happens all the time. Staff said they checked controlled drugs at handover times as there are, for a brief period, two nurses for each part of the unit. The nurse coming off duty would stay late to do this.

A consultant we spoke with told us that they felt nursing staff were stretched to their limits and they had raised this as an incident several times. They found it difficult to get a handover from nurses prior to their ward round, and sometimes had to wait a long time for a nurse to become available. The consultant said they often do the ward round by them self, using the handover sheet to check on patient care. We observed a consultant completing the ward round on their own as nurses were not able to assist.

Five of the 15 patients and relatives we spoke with specifically mentioned nurse staffing as an issue they thought detrimental to their care. One patient told us that they had had a small fall and although staff attended promptly they did not feel it would have occurred if the ward had been well staffed.

During our three visits to the ward, the deputy head of nursing for the site was observed helping on the unit with tasks such as assisting patients with feeding, and laundry changes.

We returned to the unit on 17 July 2018 to see if staffing levels had improved. There were three nurses and six health care assistants on the early shift, and three nurses and five health care assistants later on.
We observed an allied health professional changing a patient incontinent of faeces as there was no-one available to help the nurse.

On 17 July 2018 there was one nurse and one health care assistant on the 12 bedded part of the unit, with no other staff in this area. The staff nurse confirmed that they had finished washing the last patient at 2.30pm as there had been just the two of them to complete the task.

Both staff had a break at 11.30am, but were not expecting any further breaks in the afternoon, and the nurse had not taken any breaks the previous day.

At 16:04pm both staff in the 12 bedded area were assisting a patient back to bed when another patient pressed their call bell. As there was no-one else to assist, the bell rang for seven minutes before staff could attend to the second patient.

We discussed our concerns with the Director of Nursing and Quality who assured us that they were taking action to address the staffing numbers on the unit.

We returned to the unit again on 2 August 2018 during the well led part of our inspection and found staffing levels had improved. Staffing levels were four registered nurses and seven health care assistants and this had been maintained since our last visit. The planned level of staffing had been increased by one health care assistant during the day.

Staff we spoke with were positive about the improved staffing levels but did not feel confident that it would be sustained.

The trust has reported their staffing numbers below as at March 2018 for medicine:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at March 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mid Yorkshire NHS Trust</td>
<td>708.5</td>
<td>582.9</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 14.3% in medicine, compared to the 9% trust target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.4% in medicine, compared to the 12% trust target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 5.3% in medicine, compared to the 4.8% trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The below table shows total shifts filled by bank/agency qualified nursing staff and shifts left unfilled from April 2017 to March 2018 in medicine at The Mid Yorkshire Hospital NHS Trust by site:
<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>2,785</td>
<td>5,054</td>
<td>12,522</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>633</td>
<td>2,345</td>
<td>3,159</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>117</td>
<td>244</td>
<td>568</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,535</strong></td>
<td><strong>7,643</strong></td>
<td><strong>16,249</strong></td>
</tr>
</tbody>
</table>

The trust has identified five medical wards that have among the highest bank/agency usage, as a result of high vacancies. These are gate 12 acute assessment (12.2% vacancy rate), gate 43 elderly care (4.6% vacancy rate), gate A2 stroke and neurology (2.1% vacancy rate), ward six (4.2% vacancy rate) and the medical and stroke rehabilitation unit (9.0% vacancy rate).

The trust states that they have a comprehensive recruitment programme, which includes graduate, return to practice and return to the NHS and international recruitment. The trust is focusing on retention of staff and has deployed several initiatives which include career cafes and internal transfer scheme, platinum retention plan, and graduate nurse programme.

Six monthly staffing reviews ensure the workforce meets the demands of the service and allows the wards to consider new workforce models including assistant practitioners, nursing associates and pharmacy technicians.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

### Medical staffing

Two consultants visited the unit and were based at the Pinderfields hospital site. A consultant in elderly medicine and a stroke consultant both visited the unit to review patients three times a week. Junior doctors (FY2) covered the unit Monday to Friday. We were told that medical staff attended the multidisciplinary board meetings. A consultant we spoke with said that in general the stroke doctors visit in the mornings and the medical doctors in the afternoons. The consultant confirmed that there should be a junior doctor onsite, but when we visited this was not the case.

An anaesthetist provided medical cover 24 hours a day, seven days a week.

Nursing staff told us that sometimes cover was not provided for medical staff when doctors were on annual leave. Staff said medical staff were sometimes pulled back to cover shortages at Pinderfields.

A staff nurse on duty on 17 July 2018 confirmed that there was no medical cover the previous day and they had to escalate this to their manager as a patient was deteriorating and they needed a medical review. Following escalation, a doctor did come to review the patient.
The trust supplied information about their fill rates for junior doctors from 12 March to 30 June 2018. This was for all three hospital sites:

<table>
<thead>
<tr>
<th></th>
<th>Filled</th>
<th>Unfilled</th>
<th>Filled %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-18</td>
<td>506</td>
<td>44</td>
<td>92%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>645</td>
<td>68</td>
<td>90%</td>
</tr>
<tr>
<td>May-18</td>
<td>656</td>
<td>108</td>
<td>86%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>566</td>
<td>92</td>
<td>86%</td>
</tr>
</tbody>
</table>

The trust has reported their staffing numbers below as at March 2018 for medicine:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Planned WTE Staff</th>
<th>Number in post as at March 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mid Yorkshire NHS Trust</td>
<td>276.7</td>
<td>257.4</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 12.6% in medicine, compared to the 9% trust target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 5.9% in medicine, compared to the 12% trust target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 1.1% in medicine, compared to the 4.8% trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The below table shows total shifts filled by bank/locum medical staff from April 2017 to March 2018 in medicine at The Mid Yorkshire Hospital NHS Trust:

<table>
<thead>
<tr>
<th>Site</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by locum staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust wide</td>
<td>4,537</td>
<td>16,353</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.
Staffing skill mix for the 210 whole time equivalent staff working in medicine at The Mid Yorkshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics - January 2018)

Records

Patient names (prefix and surname) were visible on a board directly in front of the main reception desk. These were visible to visitors and other patients. Stickers were used to highlight patients with similar or identical surnames.

Patient records were stored in notes trolleys. The ward had two sets of notes for each patient, one for medical and one for nursing. All notes on the ward were stored in movable trolleys. None of these trolleys were lockable. Two of the notes trolleys were stored in the main corridor and a third was close to reception. These trolleys were not supervised or monitored. We observed one set of patients’ medical notes left on a desk on the main corridor unattended.

We saw a member of nursing staff using their password to enable a member of medical staff to access an online reporting system. This was in breach of the Trust’s information governance policy.

We looked at 13 sets of patients records. Medical records were untidy and badly filed. We found evidence of records not being stored correctly, filed incorrectly, not contemporaneous, not signed and not complete. Some entries were illegible.

In a minority of cases, notes were entirely loose within clear plastic folders or paper wallets, and these notes were not in chronological order. We saw evidence of loose notes for patients who had been on the ward for over a week. When we asked staff about these notes, we were told that on transfer from another site, patient notes were removed from their binding and transferred loose. Staff told us that they were awaiting new covers to enable them to file notes. No temporary solution had been put in place.

We found a monitoring tool for one patient filed in the notes of another. This was brought to the attention of staff and immediately rectified.
The electronic patient system was used to flag specific patient information, for example, a flag was used for patients living with dementia or those patients with a learning disability. A ‘VIP’ sticker was placed on medical notes of patients with a learning disability and a ‘forget me not’ sticker for patients with dementia.

Medicines

Medicines were stored in the clean utility rooms which were locked with a digital number pad to maintain security. Medicines trolleys were locked and chained to the wall when not in use.

A centrally monitored system was in place to ensure that medicines were stored at the correct temperature.

Medicines and equipment required in emergencies were appropriately stored and checked daily to ensure they were fit for use.

Controlled drugs were ordered appropriately. Record checks for stock medicines were completed each day and on all wards we visited these were correct.

We checked the contents of one medicine cupboard and found there were very high levels of stock. We found five boxes of drugs which had exceeded their expiry date. All drugs in the fridge were within their expiry date. We reported the out of date drugs to the deputy head of nursing for removal.

There was an onsite outpatient pharmacy, and inpatient medicines were provided from Pinderfields Hospital pharmacy. Pharmacy staff visited on weekdays to check stock, look at requests, reconcile medicines, and validate prescriptions. If new drugs were required for a patient at evenings or weekends, the prescription chart was sent to Pinderfields on the trust transport van, and when the prescription was ready, the transport van brought it back. If medicines were needed urgently, this could be arranged via the Pinderfields Hospital pharmacy and delivered within an hour. Staff said that non-urgent prescriptions could take between five to seven hours to return, and sometimes the prescription did not arrive until the following day.

Incidents

Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they received individual feedback from incidents and could request this via an email linked to the electronic reporting system.

Information about incidents was also shared at the safety brief which occurred at nurse handover and at the beginning of the board meeting. Health care assistants attended the beginning of the meeting and there was a quick discussion on patients at risk of falls, pressure ulcers, nutritional needs.

The ward manager informed us that due to low nurse staffing levels it was not possible to hold a regular team meeting to disseminate learning from incidents. This meant there was no forum for staff to discuss learning from incidents. The ward manager told us that staff were sent a bulletin by email and a paper copy was kept at each nurses station. We reviewed a copy of the June bulletin and noted that learning and actions from incidents was included.

The patient safety panel reviewed lessons learnt from serious incident investigations, pressure ulcers and falls. Once identified these were shared with staff via a two weekly patient safety bulletin.

The ward manager was aware of the number of incidents which were reported and received information about incidents on the ward dashboard. We saw that from October 2017 and June 2018 the unit had a total of 236 incidents. There were 106 falls, 24 pressure damage (grade 2)
and nine medication incidents. The unit had three serious incidents over the same period; all were patient falls with two resulting in a fractured neck of femur and one a fractured clavicle.

Staff we spoke with had an awareness of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients. The ward manager was aware of the DoC and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty. DoC was incorporated into the incident reporting system.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for medicine.

*(Source: NHS Improvement - STEIS (May 2017 – April 2018))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from May 2017 to April 2018.

![Graph showing breakdown of serious incidents](image)

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 18 (64% of total incidents).
- Pressure ulcer meeting SI criteria with six (21% of total incidents).
- All other categories with one (4% of total incidents).
- Treatment delay meeting SI criteria with one (4% of total incidents).
- VTE meeting SI criteria with one (4% of total incidents).
- Medication incident meeting SI criteria with one (4% of total incidents).

*(Source: Strategic Executive Information System (STEIS))
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 83 new pressure ulcers, 51 falls with harm and 33 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Mid Yorkshire Hospitals NHS Trust

1. Total Pressure ulcers (83)

2. Total Falls (51)

3. Total CUTIs (33)

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only

(Source: Safety thermometer)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We reviewed a random selection of five policies including the falls policy, the fluid balance management policy for adult patients and the safe nurse staffing policy. All were within their review date.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance. There was a process in place to ensure that clinical practice was in line with the service NICE guidance. Clinical leads carried out a gap analysis and identified actions required to address any gaps.

The care of the elderly team had designed a new patient assessment document which followed the acute care of the elderly pathway and was based on the Royal College of Physicians guidance. The document was going through the trust governance processes prior to rolling out.

Ward dashboards displayed the audits scores for the matron health check, falls prevention, pressure ulcer prevention and nutrition and hydration. However, these had not been regularly completed on the unit. From October 2017 to June 2018 there were only three entries for the matron health check (all at 97%), and one for falls prevention in June which was 100%. There were no audit results displayed for pressure ulcer prevention or nutrition and hydration.

Nutrition and hydration

There was a divisional nutritional and hydration group which focused on improvements in this area. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Patients were screened on admission and then weekly using the Malnutrition Universal Screening Tool (MUST). Food and fluid charts were completed for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic service. We saw that a referral to the dietician had been made in two patients’ notes.

Red jugs and red trays were in use to indicate to staff which patients needed assistance with their meals. Mealtimes were protected. Relatives were encouraged to stay and help with meal times if they wished.

Wards we visited had a white board in the pantry which identified if patients had specific dietary needs such as a soft diet, pureed or thickened fluids. It also stated if a patient was nil by mouth. Food menus were on a 14 day cycle to provide variety for patients. Ethnic meals could be provided and the menus were available in six different languages on request.

At one visit to the unit we observed a housekeeper serving meals at 5pm. The housekeeper should have finished her shift at 4pm but stayed on to ensure that patients got their meals, as there were only two nurses (one in each separate part of the unit) and all the health care assistants were supervising patients at risk of falls and could not help.

In the 12 bedded unit, we observed two patients who had been served a pureed diet in a lidded cup. Half an hour after the evening meal had been served, they had not received any encouragement or assistance to eat and both cups were untouched.
Six of the patients we spoke to felt that their food and nutrition was good, although one person told us that they did not receive enough fluids. Two further patients felt that food and nutrition was adequate.

We looked at five fluid balance charts and found that one was poorly completed.

There were no audit scores on the unit dashboard for nutrition and hydration. From October 2017 to June 2018 the dashboard said ‘no data’.

### Pain relief

Staff used a pain-scoring tool, from one to 10, to assess a patient’s level of pain. The pain score was recorded on the electronic clinical record system. Pain relief was provided as prescribed and there were systems in place to ensure that additional pain relief could be accessed through medical staff, if required.

Six of the thirteen patients we spoke with told us that their pain was well controlled. One person did not feel that their pain was well controlled, and told us that a lack of input from physiotherapy services meant their joints felt stiff and painful.

Pain management was audited as part of the quarterly matron health check. This was a peer audit supported by the clinical audit team and formed part of the nursing quality governance framework. The results for the division of medicine for the previous 12 months are included below;

<table>
<thead>
<tr>
<th>Pain Management</th>
<th>Q2 17/18</th>
<th>Q3 17/18</th>
<th>Q1 18/19</th>
<th>Q2 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Pain status assessment on VitalPac</td>
<td>99%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>B. Pain care plan in place where indicated (n/a if not required)</td>
<td>55%</td>
<td>41%</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>C. Evidence of pain being reassessed on regular basis</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
</tr>
</tbody>
</table>

### Patient outcomes

The service participated in relevant quality improvement initiatives, including local and national clinical audits. Local audits included infection control and hand hygiene audits, falls, pressure ulcer, fluid balance and nutrition audits which were carried out monthly or bi-monthly. However, the dashboard for the unit did not show any results of the falls prevention, pressure ulcer prevention and nutrition and hydration audits so we did not know if these had been regularly completed on the unit.

Therapy staff used a standard outcome measure (MILOA) to conduct a local audit in April 2018. Following this, they set up projects to look at setting individual goals with patients and their families, and how therapy interventions had affected length of stay. These work streams were currently ongoing.

Therapy staff told us that when nurse staffing was low they were not able to achieve the best outcomes for patients as they were needed to help with other tasks such as toileting.

Pontefract Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average. The trust achieved grade B in the latest Sentinel Stroke National Audit, which
was an improvement from the previous audit. The main stroke services were based at Pinderfields hospital and patients were transferred to Pontefract for rehabilitation.

The endoscopy service had not met the requirements of the Joint Advisory Group on Endoscopy (JAG) and had lost accreditation. Staff told us there was an action plan to work towards regaining accreditation and the division had commissioned a senior consultant to move the action plan forward.

**Relative risk of readmission**

**Pontefract Hospital**

From January 2017 to December 2017, patients at Pontefract Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - Pontefract Hospital**

- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions

![Graph](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Non-Elective Admissions - Pontefract Hospital**

- Patients in clinical haematology had a lower than expected risk of readmission for non-elective admissions
- Patients in clinical oncology (previously radiotherapy) had a lower than expected risk of readmission for non-elective admissions
- Patients in medical oncology had a lower than expected risk of readmission for non-elective admissions

![Graph](image)
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: HES - Readmissions (January 2017 – December 2017))

Sentinel Stroke National Audit Programme (SSNAP)

The Mid Yorkshire NHS Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, April 2017 to July 2017, which was an improvement from the previous audit, December 2016 to March 2017, where the hospital achieved grade C.

The combined total key indicator level in the overall scores has seen an improvement in performance from grade C to grade B in the latest audit.

Pinderfields Hospital

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C↑</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>B↑</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>A↑↑</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
<td>E↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D</td>
<td>E↓</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
<td>D↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>
• Domain 3: Thrombolysis has seen an improvement from grade C to grade B in the latest audit for both patient and team-centred performance.

• Domain 6: Physiotherapy has seen a decline in performance from grade B to grade C in the latest audit for both patient and team-centred performance.

• Domain 7: Speech and language therapy has seen a decline in performance from grade D to grade E in the latest audit for patient-centred performance.

• Domain 8: Multi-disciplinary team working has seen an improvement in performance from grade E to grade D for both patient and team-centred performance.

(Source: Royal College of Physicians London, SSNAP audit)

Competent staff

We saw from the ward dashboard that the actual appraisal rate for the unit was 69% for June 2018 which did not meet the trust target of 85%. Senior nursing staff told us that the only outstanding appraisals were those staff that were on long term leave or a career break.
We spoke to a health care assistant who had previously worked in another area. They felt they had been ‘deskilled’ on this ward.

Junior doctors told us they had a good induction when they joined the trust. Those we spoke with were able to attend their training days although they were aware this sometimes left medical staffing short on the wards.

Therapy staff told us they had bespoke in service training. They also provide extra training to the wider team. For example they had provided training to health care assistants taking part in the pyjamas paralysis challenge, to encourage patients to get up and dressed.

The unit manager told us they were exploring skill mix within the team but did not currently have any band 3 and 4 nursing staff working on the unit.

**Multidisciplinary working**

Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

There was a MDT board round on the unit Monday to Friday at 9.15am. We observed a board round on the unit, which was attended by physiotherapy and occupational therapists, the ward manager, the discharge liaison sister, a social care worker, the ward clerk and the deputy head of nursing for the Pontefract site. All patients on the ward were discussed in detail including safety risks and issues such as pressure ulcers, confusion and falls. The patient’s social situation and discharge planning were also discussed. Actions were identified and noted which required completion before the patient could be safely discharged home. Discharge planning meetings were organised to include family members in the discharge planning process.

The ward manager told us that doctors would also attend the board meeting if they were on site.

**Seven-day services**

Therapy staff on the unit provided services on weekdays only. Staff told us that weekend therapy cover was occasionally provided but this was only if staff volunteered to work an extra shift.

Therapy team leaders told us that seven day working was gradually being rolled out in therapy teams.

Nursing staff and health care assistants were encouraged to learn skills from therapy staff to provide some continuity of care when therapy staff were absent at weekends.

**Health promotion**

Leaflets covering topics including smoking cessation, hand hygiene and independent living were on display and were noted to be clean and tidily displayed. Also on display was a poster advertising the visiting stroke service.

The learning disability lead nurse carried a supply of annual health check leaflets and gave these to patients with a learning disability and their carers to encourage them to attend.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The MCA allows restraint and restrictions to be used but only if they are in a person’s best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs).

Staff we spoke with understood the basic principles of the MCA and DoLS. They told us that if they needed to complete a DoLS application they were able to access help from the safeguarding team.

However, we saw limited examples of mental capacity assessments or decisions made in line with the principles of the MCA. Where patients lacked capacity, capacity assessments and recording that the decision was in the patient’s best interests was not consistent.

It was clearly documented in one patient’s notes that they had repeatedly expressed a wish to leave, and had tried to leave the ward, for a period of about a week following their arrival. It was documented that they had a high risk of falls and had attempted to get out of bed several times. They were being supervised on a one to one basis, and a sensor mattress and bed rails were being used. We could not find any documentation of a mental capacity assessment or a DoLS application for this patient. Having discussed their care with the deputy head of nursing and the safeguarding lead, we were satisfied that the patient no longer actively wished to leave. There was no clear documentation in the patient’s notes of any capacity assessment conducted following the patient’s transfer to the ward.

We looked at the notes of one patient who had been assessed as needing mittens as they had been removing their nasogastric tube. The reason stated for the assessment was that the patient had removed their tube several times, however, on examination of the previous month’s notes, there was only one documented occasion on which this had occurred and on discussion with the ward manager it became apparent that the removal of tube had been accidental rather than intentional. A hand control mittens form had been completed and was filed in the patient’s notes with a hand control mittens care plan. Both documents suggested the following should be completed; a mental capacity assessment, a record of capacity, determination of best interest documentation, multidisciplinary team best interests meeting and a trust best interest decision form. We could not find any evidence of these documents in the patient’s notes. When we asked the staff about this they were not aware that a best interest form needed to be completed for the use of mittens.

We found issue issues with two ‘Do Not Resuscitate’ (DNACPR) forms. We saw that one form relating to a patient in the 12 bedded unit, documented that the decision had been discussed with the patient’s grandchild. The patient’s child had been a regular visitor. There was no clear documentation in the patient’s notes to show whether this decision had been discussed with the correct family member. A further patient’s DNACPR form did not clearly show whether a patient had capacity to make this decision. There was no evidence in the patient’s notes that an assessment had been completed and documented.

Mental Capacity Act and Deprivation of Liberty training completion

Staff were required to complete training in MCA and the DoLS. Information provided by the trust on 30 June 2018 showed that the overall compliance for staff within the Division of Medicine was 99% for level 1 training, which exceeded the trust target of 95%. Compliance with level 2 training was 80% and for level 3 training it was 55%, which did not meet the trust target of 85%.
The trust informed us that the reason for the level 3 training compliance being low was that initial training took place for a large number of staff in 2015 and as staff were required to complete the training every three years, a number of staff had fallen out of compliance. However, further masterclasses were planned and the trust was looking at alternative ways to provide this specialist training.

(Source: Additional data request MED 14)

### Is the service caring?

**Compassionate care**

We observed staff exhibiting kind and caring behaviour towards their patients. However, we had concerns that nurse staffing levels did not allow staff time to meet patients care needs.

Call bells were continuously ringing during our first visit to the ward and we observed these sounding for approximately five minutes. Patients were also calling out for help, but there were not enough staff available to be able to respond in a timely manner.

We spoke to a senior member of the therapy team who informed us that the unit was frequently short of nursing staff which impacted on the therapy team’s ability to support patients with rehabilitation. Therapy staff did not answer call bells as they did not feel this is their role, although they helped with other tasks where they can.

Patients and relatives we spoke with said they thought staff were very caring but they did not feel that there were enough of them. One relative told us that they were aware nursing staff could get caught up providing one to one care for other patients which meant they were not free to move around the ward to see to other patients’ needs. One patient reported they had waited for 15 minutes to be put back to bed after they had rung their call bell.

A nurse reported that another patient had been reduced to tears by the long wait for someone to take them to the toilet.

We observed one member of staff struggling with a patient who was trying to mobilise out of bed. The patient needed more than one person to assist them, and the member of staff was unable to attract the attention of anyone else on the ward as everyone was busy. After warnings to the patient that they shouldn’t attempt to get out of bed without help, the staff member was observed telling the patient in a raised voice and stern tone to ‘get back into bed now.’

When we arrived on the unit on 17 July 2018 there was a gentleman in a single bedded room close to the ward’s main entrance who was exposed from the waist downwards. This went unnoticed by staff until we asked a member of staff to attend to him.

Due to these concerns we carried out two direct observations of care using the Short Observational Framework for Inspection (SOFI) an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people’s care or treatment looking particularly at staff interactions. Both observations were carried out on the medical ward at Pontefract Hospital.

The first SOFI was undertaken in a bay occupied by four patients over a 30-minute period with recordings made at five-minute intervals. During this observation we observed kind and caring interactions from a doctor, the discharge liaison nurse and a pharmacist with the patients they had come to see. Information was discussed with patients in a way they could understand and they and their relatives were involved and given opportunity to give opinions and ask questions. No ward nursing staff entered the room during this time period but patients looked well-cared for and had their buzzers and drinks within reach. Outside the room we heard a buzzer ringing for three
minutes before this was answered. There was a visitor present in the room throughout the
observation. Data showed that there was no staff interaction with the patients for 75% of the time
frames. Patients’ mood was recorded as being positive and engaged in a task or conversation for
50% of the time frames and 50% as neutral which meant they were passive, watching or
withdrawn.

The second SOFI was undertaken in a second bay occupied by four patients over a 25-minute
period with recordings made at five-minute intervals. During this observation we observed kind
and caring interactions by two nursing staff with the patient they had come to attend to. Patients
looked well-cared for and had their buzzers and drinks within reach. Data showed that there was
no staff interaction with the patients for 78% of the time frames. Patients’ state of being was
recorded as positive on seven occasions, neutral on nine occasions (passive, watching or
withdrawn) and negative on four occasions. The four negative recordings were made because two
of the patients had periods where they looked bored, uncomfortable or in pain and were fidgeting.
One patient was trying to sleep while sat in an upright, high backed chair. Except for the two
nursing staff who entered the room to provide a direct care intervention for one patient, there were
no other staff in the room during this observation.

Friends and family Test – Response rate between March 2017 and February 2018 by site
and ward

Pontefract Hospital:

<table>
<thead>
<tr>
<th>PMSRU</th>
<th>Oct 17</th>
<th>Nov 17</th>
<th>Dec 17</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>March 18</th>
<th>April 18</th>
<th>May 18</th>
<th>June 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely and extremely likely to recommend</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95.8%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Response rate</td>
<td>20%</td>
<td>11.9%</td>
<td>26.3%</td>
<td>34.3%</td>
<td>12.5%</td>
<td>9.7%</td>
<td>28.6%</td>
<td>89.7%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Highest score to Lowest score

| Key  | 100% | 50%  | 0%   |

Note: The formatting above is conditional formatting which colours cells on a grading from
highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply
the passing or failing of any National standard.

(Source: Med 43 Ward heat maps)

Emotional support

Although nursing staff were kind. They had little time to offer patients emotional support with the
staffing levels we observed on inspection.

Information on voluntary organisations, which could provide patient and relatives with support and
advice, was displayed on the unit.

There was 24 hours access to a psychiatric liaison team.

Spiritual and pastoral support was available to patients, relatives, carers and staff. There was a
multi-faith centre on site with a chapel and a prayer room. Chaplains were available to provide
services for different faiths in the chapel or at the patient’s bedside.
Understanding and involvement of patients and those close to them

Visiting hours were at ‘any reasonable time’ and there is a limit of two visitors per bed. Families are encouraged to help patients to dress in day clothes, and to bring in toiletries and clothes for them.

 Patients and their families told us they felt involved in their care. We observed consultants talking to patients and relatives in a way they could understand. Patients and relatives were given the opportunity to give opinions and ask questions.

 Discharge planning meetings were organised to include family members in the discharge planning process. We saw this documented in patients notes.

Is the service responsive?

Service delivery to meet the needs of local people

The division had realigned their services as part of the acute hospital reconfiguration. This involved the centralisation of acute in-patient services at Pinderfields Hospital. As part of the reconfiguration they had opened two acute frailty assessment units (one at Pinderfields and one at Dewsbury and District Hospital) which accepted direct referrals. A discharge hub had been set up at both sites which could accommodate patients 24 hours a day seven days a week. Pathways to Dewsbury and District Hospital and Pontefract Hospital had been created, and these hospitals were now designated step down facilities.

Average length of stay

Trust Level

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 7.8 days, which is higher than the England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.

Elective Average Length of Stay – Trust Level

![Bar chart showing average length of stay for different specialties](chart)

Note: Top three specialties for specific trust based on count of activity.
For medical non-elective patients, the average length of stay was 6.5 days, which is similar to the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

**Non-Elective Average Length of Stay – Trust Level**

Note: Top three specialties for specific trust based on count of activity.

**Pontefract Hospital**

From February 2017 to January 2018 the average length of stay for medical elective patients at Pontefract Hospital was 3.1 days, which is lower than the England average of 5.8 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in respiratory physiology is similar to the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in medical oncology is higher than the England average.

**Elective Average Length of Stay - Pontefract Hospital**

Note: Top three specialties for specific site based on count of activity.
For medical non-elective patients, the average length of stay was 1.2 days, which is lower than the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in clinical haematology is lower than the England average.

**Non-Elective Average Length of Stay - Pontefract Hospital**

![Graph showing average length of stay for non-elective specialties at Pontefract Hospital and England average.]

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The trust had a specialist lead nurse for dementia and dementia. Patients with dementia were flagged on the system and were identified to staff at safety huddles and at board rounds. A forget-me-not scheme was in use, we saw these displayed on the board at the back of patients’ beds and in patients notes. However, there were a number of patients on the unit with dementia, yet the environment was not dementia friendly and there were no specific adjustments made for these patients.

Staff could access translation services through the switchboard. They could book a face to face interpreter or a booked call in the patient’s language. They could also book a face to face British Sign Language interpreter. Posters were displayed in over 10 different languages which gave patients information on how to get more information in their own language should they need it. We saw ‘tell us what you think’ posters and leaflets were available in several languages.

To meet the needs of patients with sensory loss, patient information was available in different formats such as braille. This could be requested via the patient advice and liaison service. The trust website had the facility to enable patients to increase the font size of the text, convert the text into different languages, read the page content aloud and download patient information leaflets as audio files.

Breakfast clubs were organised in patient bays weekly to encourage mobilisation. Domestic staff set up a breakfast table in the centre of the bay, and therapists accompanied patients to the table where they could eat and chat with other patients. Staff said this had been received positively by patients.

We noticed that patients in most rooms had access to games or activities but these were placed on a central table room in the bay and most of the patients were unable to use these without assistance from visitors or staff.

The learning disability lead nurse received a daily report, which flagged patients with a learning disability at all hospital sites. The lead nurse then visited the patient to offer support and
information. Family members or care staff from supported living were also encouraged to stay and support the patient in the hospital setting. VIP passports were in use for patients with a learning disability which included sections on health, reasonable adjustments, communication needs, decision making, support needed and eating and drinking.

Access and flow

The unit had a dedicated discharge liaison nurse and discharge co-ordinator who worked with social care providers and voluntary organisations to ensure the safe and timely discharge of patients from the unit.

Patients discharge plans were discussed at the daily board round. Actions were identified and noted which required completion before the patient could be safely discharged home. Discharge planning meetings were organised to include family members in the discharge planning process. If the patient was progressing, they were marked as green. If they were not progressing they were marked as red, and a joint plan was formed to try and resume the patient’s progress.

Therapy staff told us that sometimes patients can be fit to go home but care packages were not picked up in a timely manner. They said that patients then had to stay in hospital longer and in some cases they deteriorated.

Referral to treatment (percentage within 18 weeks) - admitted performance

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average. In the latest period, March 2018, 85.6% of this group of patients were treated within 18 weeks versus the England average of 88.9%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>93%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>
Five specialties were below the England average for admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>92.3%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>80.4%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.9%</td>
<td>82.9%</td>
</tr>
<tr>
<td>General medicine</td>
<td>61.9%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>60.0%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Patient moving wards per admission**

The trust stated that they were unable to provide the data requested as their system does not have the functionality to differentiate between moves for clinical and non-clinical reasons.

(Source: Trust Routine Provider Information Request P51)

**Patient moving wards at night**

The trust stated they are only able to provide comparative data for the last six months, due to a reconfiguration of their acute hospital services.

Data provided by the trust indicates there were 960 ward moves at night across 24 wards from October 2017 to March 2018.

The average number of moves per ward ranged from none to 34. There were nine bed moves at night for this period at the Pontefract Medical and Stroke Rehabilitation Unit (PMSRU), 84 at Dewsbury and District Hospital and the remaining 867 were at the Pinderfields site (Source: Trust Routine Provider Information Request P52)

**Learning from complaints and concerns**

The ward manager we spoke with was aware of themes and trends from complaints. Complaints were discussed with individual staff and any learning was shared with staff through a bulletin. However, there were no team meetings on the unit for staff to discuss and learn from complaints.

The ward dashboard showed that from October 2017 to June 2018 the PMSRU had received two complaints which related to staffing levels.

Information on how to complain was clearly displayed on the unit.

**Summary of complaints**

From April 2017 to March 2018 there were 281 complaints about medical care. The trust took an average of 25 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 30 working days.
The most common subjects of complaint were:

- Patient care (157 complaints, 56% of total complaints for this core service)
- Admissions and discharges (excluding delayed discharge due to absence of care package) (40 complaints, 14% of total complaints for this core service)
- Staff’s values and behaviours (33 complaints, 12% of total complaints for this core service)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were 59 compliments within medicine:

- Pinderfields Hospital: 28 compliments
- Dewsbury and District Hospital: 31 compliments

There were no compliments logged by the Trust for the unit. However, we observed a number of ‘thank you’ cards displayed on notice boards in the unit.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The Pontefract Medical and Stroke Rehabilitation Unit (PMSRU) was part of the Division of Medicine which was led by a clinical director, a director of operations and two assistant directors of nursing.

The unit was managed by a ward manager with the support of the deputy head of nursing. The ward manager felt well supported by her line manager but said that she would like to see more of her on the unit because the deputy head of nursing was pulled towards Pinderfields.

The deputy head of nursing was a fairly new post which had been put in place by the senior leadership team to support the teams on the Pontefract site.

The ward manager’s role was split into 60% clinical time and 40% managerial time. However, she said it was rare to have 40% managerial time because she was often included in the nursing numbers and looking after a cohort of patients.

The ward manager told us that communication had improved and the executive team were more visible and approachable. Both the Chief executive officer and the director of nursing and quality had visited the unit and they sent weekly updates to staff.

All staff spoke highly of the Chief Executive, complimenting his approachable and visible leadership style.

Therapy staff told us that they felt supported by their immediate line management who were usually available to speak to despite being based at a different site.

Therapy and nursing staff were able to attend a certified leadership training provided by the organisation. Nursing sisters, charge nurses and ward managers could also apply to go through the Royal College of Nursing leadership accreditation scheme. Staff attributed this investment in their leadership development to the new chief executive and the executive team. They welcomed this investment in their development.
**Vision and strategy**

The Division of Medicine had a clear vision and strategy. They had recently implemented a new model of care with the acute hospital reconfiguration. Staff we spoke with were aware of this and had been involved in the consultation and planning process.

The trust vision, mission and strategic aims were displayed on notice boards around the medical wards.

**Culture**

Staff we spoke with told us that they were happy to work for the organisation and that the culture had improved was more open. Two members of staff on the ward had worked for the Trust for more than twenty years.

However, staff we spoke with said that poor staffing levels were affecting morale which was low on the unit. Staff said they were proud of the work they did but they did not feel supported by Pinderfields.

Despite this staff supported each other well and there was good team work. Staff were proud of the services they provided to patients and said when staffing levels were good the unit functioned well and patients were happy with their care.

The trust had a freedom to speak up guardian. Staff we spoke with were aware of this role and how to contact the guardian if necessary.

**Governance**

The directorate had governance arrangements in place with clear routes for concerns to be escalated from staff to the senior management team and a clear line of escalation from the divisional team to the trust board via the board committees.

However, there were no team meetings on the unit which did not give staff the opportunity to discuss issues and concerns which needed escalating. There was no forum where shared learning from incidents and complaints could be discussed. With the exception of the email bulletins sent to staff by the ward manager, there was no mechanism to pass information down to staff.

There was a lack of oversight of some issues relating to medicines and who was accountable for this. For example, staff were unclear whose responsibility it was to check expiry dates of medicines and to rotate the stock.

We found little evidence of local audit being used to improve services. According to the ward dashboard, falls prevention, pressure ulcer prevention and nutrition and hydration audits had not been regularly completed on the unit.
Management of risk, issues and performance

The ward manager was aware of the main risks to the unit and identified these as;

- Patient falls
- Medical cover
- Nurse staffing

The unit did not have a separate risk register. The ward manager escalated risks through her line manager, the deputy head of nursing. The risk of low nurse staffing levels had been escalated but there was no evidence that this had been taken seriously or addressed. The deputy head of nursing was present on the unit during our inspection and did not appear to recognise that staffing levels were at times inadequate.

Information management

Information management systems were used effectively in patient care and for audit purposes to monitor and improve quality.

The ward manager had access to information a ward dashboard called a ‘heat map’. Heat maps were available for all medical wards and contained monthly data on staffing, patient safety, infection prevention and control, patient experience and nursing quality governance. The heat map was being further developed to provide additional data to ward managers.

Engagement

Staff told us they had been consulted on plans or service changes affecting them, however, staff on the Pontefract site said they felt a little isolated from the main site at Pinderfields.

The trust held an annual staff awards event to recognise and celebrate excellence. Staff and teams could also be nominated for ‘My Star’ awards. Winners would receive gift vouchers and were presented with a framed certificate.

The executive team had awarded all staff an additional day off in recognition for their hard work and efforts.

Notice boards displayed thank you cards and letters from patients and relatives. We also saw ‘what we are proud of’ information displayed on the unit.

There was a patient engagement strategy. Patient experience was discussed every four weeks at the ward manager quality meeting. A patient representative or members of the PALS team were invited to the meeting to contribute to the discussion.

Wards displayed ‘listening to you boards’ with details of issues patients had raised and what solutions had been put in place. We saw that wards displayed a visitor’s charter which included an explanation of when / why patients no longer needed a hospital bed.
Learning, continuous improvement and innovation

Staff were encouraged to undertake a service improvement project as part of the leadership programme. Cardiology nurses had produced an information booklet for patients attending the nurses led cardiology clinic.

The division carried out rapid improvement projects to improve services. There was support for staff who wanted to improve services.

The trust had an improvement work stream to reduce patient falls which was led by the falls prevention practitioner. The falls work stream was in collaboration with the improvement academy and commissioners and was underpinned by a comprehensive action plan. From April 2017 to January 2018 the trust achieved a 16% reduction in falls with harms against a target of 10% compared to the previous year.

Staff on the unit were aware of the falls work stream and had introduced a number of measures to reduce patient falls.

Staff were rewarded for innovative work through the staff awards scheme.
Facts and data about this service

The Mid Yorkshire Hospitals NHS Trust provides maternity services over three hospital sites, and in the community. Following a service re-design in September 2016, all inpatient and obstetric led maternity services were amalgamated on the Pinderfields Hospital site.

Maternity services at Pontefract Hospital include antenatal clinics, an antenatal day unit, and a midwifery-led (standalone) birth centre.

The Friarwood birth centre has four rooms, one of which has a large birthing pool that mothers can use for labour and delivery. The birth centre is in within the grounds of the hospital, with no other inpatient obstetric or neonatal services onsite. The unit therefore supports low risk women who want a birth in a ‘home away from home’ setting. Those considered high risk or who require additional care are transferred to Pinderfields Hospital.

From January 2017 to December 2017 there were 5,925 deliveries at the trust. A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at The Mid Yorkshire Hospitals NHS Trust – Comparison with other trusts in England
A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (January 2017 to December 2017)</th>
<th>MID YORKSHIRE HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,854</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>71</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mother’s age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>268</td>
<td>4.5%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,774</td>
<td>80.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>748</td>
<td>12.6%</td>
</tr>
<tr>
<td>40+</td>
<td>135</td>
<td>2.3%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td>5,925</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics
Notes: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the chart below.

Number of deliveries at The Mid Yorkshire Hospitals NHS Trust by quarter

SOURCE: HES - Deliveries (January 2017 - December 2017)

From July 2017 to June 2018, there were 6,365 deliveries at the trust. Of these, 198 deliveries were at the Friarwood birth centre, Pontefract Hospital.
Is the service safe?

Mandatory training

Mandatory training data was not available for staff at this location. The data presented relates to staff within maternity services across the trust.

All attendance at training provided by the service was monitored by the midwifery clinical educator and matrons. Staff were automatically rostered to attend mandatory training. We were told that non-attendance at mandatory training was treated seriously and escalated to the matrons and IHOM, as required.

Mandatory training completion rates

The trust set a target of 95% for completion of level 1 (core) mandatory training, and 85% for level 2 (role specific) mandatory training.

Trust level

Breakdowns of compliance for mandatory training courses for all applicable staff in maternity services at the trust as of June 2018 were provided.

The table below shows core training course compliance for all staff within the service, against a trust target of 95%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity Awareness</td>
<td>449</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 1</td>
<td>439</td>
<td>450</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety Level 1</td>
<td>430</td>
<td>450</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>422</td>
<td>450</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>387</td>
<td>450</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>377</td>
<td>450</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td><strong>2504</strong></td>
<td><strong>2700</strong></td>
<td><strong>93%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Overall, 93% compliance was achieved for the core mandatory training courses shown above, just below the trust target of 95%.

The trust target was met for three of the six mandatory training courses; a fourth (infection control) fell slightly short of target (94%). Compliance was not achieved against trust target (95%) for information governance (86%) and fire safety (84%) training courses.
The table below shows core training course compliance for applicable (role specific) staff within the service, against a trust target of 85%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management Level 2</td>
<td>266</td>
<td>275</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>398</td>
<td>419</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation Training</td>
<td>358</td>
<td>394</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling Level 2</td>
<td>305</td>
<td>357</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>348</td>
<td>423</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety Level 2</td>
<td>298</td>
<td>395</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Overall total</td>
<td>1994</td>
<td>2285</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Overall, 87% compliance was achieved for the role specific mandatory training courses shown above, surpassing the trust target of 85%.

The trust target was met for five of the seven mandatory training courses; a sixth (patient safety) fell slightly short of target (82%). Compliance was not achieved against trust target (85%) for health and safety level 2 training (75%).

Mandatory training for staff working in maternity services should include neonatal and obstetric emergencies training as a minimum (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

Midwives and health care assistants (HCA) attended a one-day Yorkshire Maternity Emergency Training (YMET) obstetric mandatory programme; which included obstetric emergencies, mandatory skills and drills, deteriorating patient, sepsis, and human factors training. Managers expected staff to attend the annual YMET as a priority.

The service provided trust-wide data for the maternity workforce that showed 95% of all applicable staff (356 of 375) had completed YMET training as of the end of June 2018. Data was provided for staff groups, which showed 96% of qualified midwives and nurses, 92% of maternity support workers and assistants had completed the training.

At our previous inspection in May 2017, we found there was not a regular programme of skills and drills at the birth centre. At our recent inspection, all staff we spoke with said they had been involved in regular skills and drills training.

In addition to annual skills and drills (YMET) training, staff told us that regular ad-hoc skills and drills training took place at the birth centre. Previous ad-hoc skills and drills training had included responding to post-partum haemorrhage, cord prolapse, eclampsia, shoulder dystocia, and vaginal breech scenarios.

We reviewed data provided by the trust, which showed 99.5% of qualified midwives and nurses across at trust-level (241 of 242) had completed fetal (CTG) monitoring training.
The trust informed us that they had recently started providing voluntary third and fourth degree tear training to maternity services staff. We reviewed a training agenda and saw the programme began in 2017 and had 24 attendees over the first two courses. A further teaching session was planned for the October 2018. Senior staff told us they expected more attendees over the next 12 months, now that the study days funded by Health Education England had been completed.

The Women’s and children’s group action plan (2017) detailed that neonatal resuscitation training was to be provided to all maternity service staff as mandatory training, with an implementation date of August 2018.

**Safeguarding**

**Safeguarding training completion rates**

**Trust level**

The trust set a target of 95% for completion of level 1 (core) safeguarding mandatory training, and 85% for level 2 and level 3 (role specific) safeguarding mandatory training.

A breakdown of compliance for safeguarding mandatory safeguarding training courses for all applicable staff in maternity services at the trust as of June 2018 was provided.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (L1)</td>
<td>448</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (L2)</td>
<td>183</td>
<td>195</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (L3)</td>
<td>190</td>
<td>205</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (L1)</td>
<td>443</td>
<td>450</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (L2)</td>
<td>351</td>
<td>399</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met completion targets for all five safeguarding training modules for which maternity services staff were eligible.

Midwives received annual safeguarding level three training in line with the intercollegiate guidelines. As of June 2018, records showed 93% of midwives had completed this training against a trust target 85%.

There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children at the trust, based at Pinderfields Hospital. The safeguarding midwife was integrated into the safeguarding team.

We reviewed a CQC action plan developed by the service (dated to July 2018) that detailed staff at the location had regular safeguarding supervision sessions with the safeguarding lead midwife.

Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. Staff told us they were happy to contact the safeguarding team/midwife for advice and support if required. Staff also said that there was a local authority domestic violence group that could be accessed for information and advice.
There was a safeguarding integrated care pathway in use across maternity services at the trust that utilised an established vulnerability assessment tool. It provided a contemporaneous record of care, contacts and conversations that the midwife has had with the mother and other professionals, with the information transferred to the records of the new baby. ‘Flags’ were used in patient care records and on electronic systems to alert staff to safeguarding concerns.

From April 2018 to March 2018, 296 child safeguarding referrals and 23 adult safeguarding referrals were made by maternity services staff at the trust.

The trust has a Female Genital Mutilation (FGM) policy in place (July 2017). The policy requires practitioners to complete an incident form for every case of FGM or suspected FGM that is identified during the delivery of healthcare within the Trust. The Safeguarding Team are alerted to the incident report via the incident reporting system. Training on FGM is delivered through the trust safeguarding training.

Access to the birth centre was via an intercom system. There were surveillance cameras in place that enabled staff to monitor people visiting and leaving these areas and helped keep the women, their baby’s and staff safe.

**Cleanliness, infection control and hygiene**

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks with hand washing technique signs. Hand gels were located at entrances with signs encouraging their use, and throughout clinical areas.

We saw staff washing their hands and using hand gel between patients, as appropriate. All staff we met adhered to arms bare below elbows guidance.

Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

Clinical areas were visually clean, and the cleaning schedules we reviewed were fully completed. We saw infection, prevention and control flowcharts displayed that showed cleaning procedures for different environments and equipment. Infection prevention and control information posters and leaflets were displayed in the areas visited.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services at the trust in the last 12 months. Single rooms were available for the isolation of patients, if needed.

The service carried out monthly infection, prevention and control audits. June 2018 data showed overall compliance (across 12 individual measures) was 99% at the location.

In the 2017 CQC maternity survey, the trust scored 9.0 out of a possible 10 for the cleanliness of rooms and wards; this was similar to the England average.

**Environment and equipment**

Maternity services at Pontefract Hospital included antenatal clinics, an antenatal day unit, and a midwifery-led (standalone) birth centre.

The Friarwood birth centre had four rooms, one of which had a large birthing pool that mothers could use for labour and delivery. There was also a postnatal room with a double bed; and partners could stay with the woman and baby following delivery.
Staff confirmed they had sufficient equipment to meet patient needs and appropriate training to use it.

The clinical equipment checked was found to have in date electrical testing labels.

We reviewed a variety of emergency and essential equipment across the maternity service. This included adult resuscitation trollies, emergency drug boxes, resuscitaires, emergency trolley box, sepsis box, post-partum haemorrhage (PPH) eclampsia and cord prolapse emergency trollies. During the inspection, we found all checks on emergency and essential equipment were complete.

There was adequate equipment in the birth centre to meet patients’ needs. This included a variety of equipment for women to use in labour; for example, birthing balls, birthing stools, birthing couches, and TENS machines.

Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation across clinical areas. The utility and stock rooms we inspected were clean and well organised.

Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use. Labels were available and used appropriately.

Assessing and responding to patient risk

The service had escalation policies and guidance in relation to a deteriorating woman or baby. These included a clinical practice care pathway for early recognition of the severely ill pregnant women (review date, April 2020), transfer of a sick newborn to neonatal services (review date, September 2019). There was also guidance on physiological observation of women in maternity (review date, May 2020), and a maternity services newborn resuscitation policy (review date, February 2020).

There were robust midwifery led care policies, which identified the criteria for women being able to deliver within the unit (review date, June 2019) and at home (review date, January 2020). We reviewed the birth centre guidelines and found comprehensive guidance about admittance criteria and risk factors, review and monitoring of higher risk (outside of criteria) women, multidisciplinary care planning, admission and assessment, labour and birth, management of obstetric emergencies, and transfer procedures.

The trust reported that in the 12 months prior to our inspection, there were no out of criteria women with risk factors admitted to the birth centre.

Risk assessment at antenatal booking took place for all women to determine whether individuals were high or low risk. We reviewed three sets of patient records at the site and found good documentation of medical, social and mental health assessments, which were fully completed in all cases. Care pathways (including changes to the care pathway) were clearly documented in all the records reviewed.

The unit undertook intermittent auscultation for low risk women during labour, in line with national guidance (NICE 2014. Intrapartum care: care of healthy women and their babies during childbirth, Clinical Guideline 109). Senior staff told us that the service was considering employing a ‘fresh ears’ approach to intermittent auscultation, whereby a second midwife would confirm the fetal heart rate pattern every hour.

Midwifery staff identified women showing signs of early deterioration by using an early warning assessment tool known as the Modified Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. Two of the records we inspected which required the use of the MEWS tool were completed appropriately.
The service confirmed that they had not completed a MEWS audit in the 12 months prior to our inspection, to ensure compliance with monitoring and escalation of deteriorating patients. However, we did see evidence that MEWS was included within the scope of the 2017 annual record keeping audit, and the service continued to implement and embed recommendations and learning from the 2016 audit. Following the inspection, the trust provided us with provisional findings from the 2018 Mews Audit (completed August 2018), that had been ongoing at the time of our inspection. As these had not been quality assured we do not present them here. The trust informed us that once data analysis was finalised, a full audit report would be completed which will include an action plan to address the improvement requirements identified.

At our previous inspection in May 2017, we found there was not a regular programme of skills and drills at the birth centre. At our recent inspection, all staff we spoke with said they had been involved in regular skills and drills training.

There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to Pinderfields Hospital. Staff informed us as soon as they were concerned they called for an emergency response ambulance.

Data provided by the trust showed 91% of applicable maternity services staff had received resuscitation training as of June 2018. The Women’s and children’s group action plan (2017) detailed that neonatal resuscitation training was to be provided to all maternity service staff as mandatory training, with an implementation date of August 2018.

During our recent inspection, we observed good swab counting practices in the surgeries inspected at Pinderfields Hospital. However, this could not be evidenced by audit results. The Clinical Audit Programme and Action Plan Obstetrics/Midwifery Update (July 2018), did not show that a ‘swab count’ audit had been conducted in 2017 to 2018. A ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. Therefore, we were unable to comment on the use and documentation of ‘swab counts’ in the wider service.

Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

**Midwifery and nurse staffing**

The service used Birthrate Plus to enable a comprehensive review of midwifery staffing numbers based on the different models of care. A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the current funded establishment of 222.87 midwives was correct for the activity in the maternity service at the trust; and took into account women that may birth in other units but whom required antenatal and postnatal care from the maternity service.

Most midwives at the service were employed as ‘rotational midwives’. Staff work within their preferred area of work forming a ‘core’ element, but they can be redeployed to work on other wards/department within the service at short notice. For example, to cover unplanned sickness or to cover planned sickness or annual leave on other departments.

Birth centre establishment staffing at the location was comprised of two midwives and one healthcare assistant. On-call cover for the birth centre was provided by the community midwifery team.

There were two band seven community midwifery team leaders at the service. One responsible for the Pontefract community team and Wakefield community team, and one responsible for the Dewsbury community team.
The service had an escalation policy (review date August 2019). The policy provided guidance for maternity staff about clinical decision making and required actions in the event of a situation where capacity and complexity of workload presented challenges in the delivery of a safe maternity service for women and their babies.

At the commencement of shifts (07.30/20.00) the shift lead midwife at the birth centre documented and assessed workload and staffing within their unit and documented this on the birth centre data entry sheet every four hours.

The Pinderfields birth centre shift lead Midwife contacted the birth centre at commencement of each shift to obtain an overall view of workload and staffing at the birth centres.

If issues arose regarding staffing or workload at the birth centres in hours, the birth centre manager/maternity matron for community and outpatients was informed to provide support with the redeployment of staff, or redirection of women to another birth centre.

If support could not be obtained from other birth centres or staff within the outpatient areas, the labour ward manager/maternity matron for inpatients was contacted to support management.

If issues arose out of hours, the shift lead midwife at Pinderfields birth centre was required to liaise with the labour ward coordinator. They would then consider re-allocation of staff already on duty or rostered to work, or call community midwifery support according to the escalation rota following discussion with the midwifery advisor on-call.

The trust did not provide us with midwifery and nurse staffing information for individual locations. Therefore, the data below is presented for maternity services at trust-level. The one exception to this is bank and agency staff use, for which location level information is presented.

We also note, that despite good overall staffing figures across the service, we were concerned that staff were not allocated properly across the service to meet service need. This is explained in more detail in the Responsive (access and flow) section of the report.

**Planned vs actual**

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017 - March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the current funded establishment of 222.87 midwives was correct for the activity in the maternity service. During our inspection, senior staff told us that 217 WTE midwives were contracted within the service. This equated to a nursing and midwifery staffing fill rate of 97.4% within maternity services at the trust.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 1.0% in maternity services, meeting the trust’s 9% target.

During this period, there was a 3.6% vacancy rate among community midwives at the trust.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

During our inspection, senior staff told us that the trust maternity service had funding for 228.87 WTE midwives, and 217 WTE midwives were contracted. This meant there was 11.87 WTE vacancies at trust level. This equated to a vacancy rate of 5.19%, which met the trust’s 9% target.

Senior staff described they had gained permission to overrecruit midwifery staff, and there was a rolling programme of recruitment. They told us that 9.2 newly qualified WTE midwives had been appointed in in June 2018; and were scheduled to commence employment October 2018. They also advised us that they would be advertising for additional post shortly, as part of their rolling programme of recruitment.
**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 13.4% in maternity;

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Total staff leavers</th>
<th>Average WTE establishment</th>
<th>Turnover rate</th>
<th>12% target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; midwifery staff (Qualified nurses)</td>
<td>28.0</td>
<td>215.1</td>
<td>13%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>2.0</td>
<td>8.3</td>
<td>24.2%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30.0</strong></td>
<td><strong>223.4</strong></td>
<td><strong>13.4%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

The trust did not meet the 12% turnover target for qualified nursing or midwifery staff.

During this period, there was a 11.3% turnover rate among community midwives at the trust, and a 14.3% turnover rate among maternity ward midwives at the trust.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Senior staff told us that the turnover rate had improved in the latter half of the reporting period described above. They attributed higher rates of turnover earlier in the reporting period to post-reconfiguration of services. The trust provided data that showed from October 2017 to March 2018, the midwifery turnover rate was 5.31% (14 leavers). This was within the trust target of 12%. The service attributed current trends in staff turnover to both the retirement of staff and the transient nature of newly qualified midwives. The service was undertaking an age profile review of the midwifery workforce to inform future workforce and succession planning.

**Sickness rates**

From March 2017 to February 2018, the trust reported a sickness rate of 6.3% for qualified nursing and midwife staff in maternity services.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff Sick Days</th>
<th>Staff days</th>
<th>Sickness rate</th>
<th>4.8% Target Met (Yes/ No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; midwifery staff</td>
<td>4,959.6</td>
<td>79,088.5</td>
<td>6.3%</td>
<td>No</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>189.8</td>
<td>2,645.1</td>
<td>7.2%</td>
<td>No</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,149.4</strong></td>
<td><strong>81,733.6</strong></td>
<td><strong>6.3%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

The trust did not meet the sickness rate target of 4.8% for qualified nursing or midwifery staff.

During this period, there was a 7.5% sickness rate among community midwives at the trust.
A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the sickness rate among midwifery staff was marginally above trust target of 6.3%, and stood at 6.76%. However, that the sickness rate was improving.

During our inspection, senior staff told us that the sickness rate among midwives had improved, and in June 2018 stood at 4.6%; which was within trust target. In addition, that the sickness rate for community midwives had been reduced to 5.1%.

**Bank and agency staff usage**

The table below shows the total number and proportion of shifts available, those filled by bank qualified midwifery bank and agency staff, and shifts left unfilled from April 2017 to March 2018 in maternity services at the location:

<table>
<thead>
<tr>
<th>Total number of shifts available</th>
<th>730</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of shifts filled by bank staff</td>
<td>25</td>
</tr>
<tr>
<td>Proportion of shifts filled by bank staff</td>
<td>3.4%</td>
</tr>
<tr>
<td>Number of shifts filled by agency staff</td>
<td>0</td>
</tr>
<tr>
<td>Proportion of shifts filled by agency staff</td>
<td>0.0%</td>
</tr>
<tr>
<td>Number of shifts filled by bank or agency staff</td>
<td>25</td>
</tr>
<tr>
<td>Proportion of shifts filled by bank or agency staff</td>
<td>3.4%</td>
</tr>
<tr>
<td>Number of shifts not filled</td>
<td>2</td>
</tr>
<tr>
<td>Proportion of shifts not filled</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

As can be seen, there was low reliance on the use of bank staff at this location. In addition, no agency staff had been used during this period.

The service used NHS professionals (NHSP) to fill gaps in the planned number of staff. A number of substantive staff were signed up to NHSP, and the agency also provided a number of familiar staff to the maternity unit, this provided continuity.

Senior management had implemented changes in the provision of absence staffing cover since our last inspection. They had encouraged more substantive staff to join NHSP, increasing bank staff availability. They also offered unfilled shifts as overtime to contracted staff, if not filled by NHSP staff, two weeks before shifts commencing. Agency staff were now used as a last resort. We compared spending on bank and agency staff in November 2017 to spending in March 2018. We saw that agency staff spend had fallen by 92%, and bank staff spend had increased by 77%. Figures were not inclusive of overtime spend.

**Midwife to birth ratio**

The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance; Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007).

From January 2017 to December 2017, the trust had a ratio of one midwife to every 26.88 births. This was similar to the England average of one midwife to every 25.46 births, and met the
recommended minimum ratio of one midwife to every 28 births. The service did not include maternity support workers within the establishment.

(Source: Electronic Staff Records – EST Data Warehouse)

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper detailed the midwife to birth ratio as 1:28 at the trust. This met the recommended minimum ratio.

The birth centres operated under a flexible staffing model, supported by community midwives, to deliver one-to-one (1:1) care in established labour. Low risk postnatal women within the units were supported by the healthcare assistants. Therefore 1:1 care was not reported upon in the midwifery-led care setting, as the staffing model and escalation procedure meant that all care was 1:1.

There were 19.44 WTE midwives in the Pontefract community midwifery team. The average community caseload within the Pontefract community team was 132 women per WTE midwife (based on number of bookings), this was not in line with national recommendations. The current recommended Birthrate plus ratio, allowing for some changes in allowances and the NICE Guidance since 2009, is 96 cases per WTE midwife.

The service had recently begun reporting midwifery caseloads against the number of live pregnancies, as using the number of bookings would include a proportion of women who experience an early miscarriage and therefore do not require ongoing community care beyond the booking appointment. Following this methodology, the community caseload within the Pontefract community team was 70 women per WTE midwife (based on number of live births). Using the live birth denominator is a useful additional measure of community midwifery activity. However, current guidance is calculated using cases (number of bookings). In the guidance, the term ‘cases’ is used rather than ‘births’ as not all women will have delivered in the local maternity unit, so will not be included in the total births for the obstetric unit. The total number of cases will reflect the local population of women having delivered along with those that may not complete their pregnancy.

Medical staffing

Maternity services offered at Pontefract Hospital were midwife-led. At the site, medical staff who provided clinics for women who required obstetric-led care or review closer to home were based at Pinderfields Hospital. Therefore, we do not report on medical staffing per se at this location.

Records

We saw secure storage facilities for records at the midwife-led unit. Electronic records were also kept, and procedures for safe storage were in line with data protection requirements.

Handheld notes were carried by women throughout pregnancy, in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3.

The service completed bi-annual record keeping audits. We reviewed the audit completed in December 2017, which was submitted to the Maternity Clinical Governance Group. Across maternity services at the trust, a total of 167 sets of maternity case notes and / or hand held notes were audited. These included 57 antenatal records, 71 intrapartum records, and 39 postnatal records.

The results showed improved compliance with antenatal record keeping, particularly around documentation of CTG monitoring when compared to the previous audit. There was also a significant compliance increase in full recording of mental health risk assessments, and birth plans. Recording compliance for intrapartum drug sensitivity/allergy and verbal consent for all intrapartum procedures had increased since the last audit was undertaken. Postnatal documentation of perineal trauma (if appropriate) was also improved.
Areas of concern included a fall (from the previous audit) from 97% to 89% in recording maternal pulse on the first auscultation of the fetal heart, and also a reduction from 98% to 75% in recording the fetal heart every 5 minutes for over a minute within the second stage of labour. Similarly, a reduction from 78% down to 58% was seen in palpating and documenting maternal pulse every 15 minutes in the second stage of labour.

Following the audit, an action plan was put in place. Ongoing activity to monitor changes in compliance included a random sample of eight maternity records per month at each location from January 2018, to be collated for the next record audit report.

We reviewed five sets of patient records and found that a risk assessment for obstetric / medical history and social history were carried out in all cases. Care pathways (including changes to care pathways) were clearly documented the records reviewed.

There were good standards of intrapartum documentation in the relevant care records reviewed. This included documentation of risk assessments (using SBAR forms), modified early warning scores (MEWS), and appropriate labelling and storage of CTGs. All notes were dated and signed with NMC/GMC numbers.

During the inspection, we saw three separate entries on the maternity risk register relating to maternity service records; these were rated as presenting a moderate to high risk. All three entries centred around issues with the main maternity record software system. Staff we spoke with during our inspection reported the system was sometimes cumbersome to navigate, but overall, they found the system adequate.

The senior management team were acutely aware of the risks involved, and were currently reviewing options to implement a new paperless system when the current software license expired (2019). The service had also developed a task and finish group to plan, evaluate and adopt a paperless postnatal record. We reviewed relevant risk register entries and saw that risks had been appropriately monitored and mitigated. We also saw there was an electronic maternity system action plan 2018 in place, which showed progress towards against a new digital maternity plan for the service.

**Medicines**

Medicines that required storage at a low temperature were stored in specific locked fridges. Medicines that did not require refrigeration were stored in locked cupboards and trolleys in all clinical areas. Fridge and cupboard temperatures were monitored remotely.

The emergency drugs boxes we inspected were all appropriately sealed and within date.

Records showed the administration of controlled drugs were subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded. Records showed controlled drugs were checked in line with trust policy.

The trust audited the safe storage of medication on maternity wards and clinics twice a year, and report results to the Medicines Optimisation Group and at a divisional level.

The April 2018 medicines audit showed that Pontefract maternity services were compliant with the safe and secure storage of medicines, and no expired medicines were identified. However, the audit did find the antenatal clinic and the midwifery-led unit had the entry code written on their treatment room door with the door unlocked. As such, they were identified for re-audit by the medicines optimisation nurses.

However, during our inspection, we identified some paper copies of patient group directions (PGDs), that allowed midwives to administer certain medicines without a prescription, were out of
date. Individual midwives who could administer the medicine under the PGD were not listed and had not signed the individual authorisation form attached to the end of each PGD, as required by trust policy.

Staff had access to up to date electronic medicine policy guidelines via the trust intranet and the trust pharmacist visited the wards and departments weekly.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant), with 2 incidents (40% of total incidents).

- VTE meeting SI criteria, with 1 incident (20% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant), with 1 incident (20% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only, with 1 incident (20% of total incidents).

(Source: Strategic Executive Information System (STEIS))

In addition to those described above, a serious incident had occurred in maternity services May 2018. This was classified as Maternity/Obstetric incident meeting SI criteria: baby only.
None of the serious incidents reported within maternity services during the period May 2017 to May 2018 had occurred at Pontefract Hospital.

The trust had a policy for reporting incidents, near misses and adverse events in maternity services. Staff we spoke with said they were encouraged to report incidents and were aware of the process to do so.

Staff reported incidents on the trust’s electronic incident-reporting system. The governance midwife and consultant obstetrician (both RCA trained) lead on serious incident investigations, supported by multidisciplinary colleagues as necessary.

We reviewed three completed serious incident root cause analysis (RCA) reports and associated actions plans, which identified areas of good practice and areas of concern, contributory factors and recommendations. We observed appropriate referral to external agencies, and inter-agency working, where appropriate.

We reviewed minutes of Maternity Clinical Governance Group meeting minutes (December 2017 to June 2018) and found discussion of serious incidents, RCA reports, clinical incidents and the RCA action log were standing agenda items.

During our inspection, we reviewed the maternity service RCA action log and found three outstanding actions; these had been granted an extension and appropriately monitored. We saw actions from one serious incident placed on hold due to external agency involvement. An additional 11 actions from a recent serious incident were due to be added to the log, pending commissioner approval.

Between July 2017 and June 2018, there were 172 incidents reported by maternity services at the location. The trust provided summary information data, which thematically categorised incidents. However, we were not able to ascertain levels of harm (for example, no harm, moderate harm, or severe harm) from the data. Nor were we able to identify specific areas of the maternity services to which incidents related.

As shown in the table below, of the 172 incidents, most related to ‘transfer’ (n=27, 15.7%), ‘transfusion of Blood related problem’ (n=24, 14.0%), and ‘test results / reports’ (n=22, 12.8%). We amalgamated 22 categories where four or less incidents per category were reported over the 12-month period.

<table>
<thead>
<tr>
<th>Incident category</th>
<th>Total incidents reported at location</th>
<th>Proportion of incidents reported at location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer</td>
<td>27</td>
<td>15.7%</td>
</tr>
<tr>
<td>Transfusion of Blood related problem</td>
<td>24</td>
<td>14.0%</td>
</tr>
<tr>
<td>Test results / reports</td>
<td>22</td>
<td>12.8%</td>
</tr>
<tr>
<td>Laboratory investigations</td>
<td>16</td>
<td>9.3%</td>
</tr>
<tr>
<td>Appointment</td>
<td>13</td>
<td>7.6%</td>
</tr>
<tr>
<td>Patient's case notes or records</td>
<td>8</td>
<td>4.7%</td>
</tr>
<tr>
<td>Injury or poor outcome for the mother</td>
<td>8</td>
<td>4.7%</td>
</tr>
<tr>
<td>Electronic Patient Record</td>
<td>6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Communication between staff, teams or departments</td>
<td>5</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
At our previous inspection in May 2017, we identified that the service was learning from incidents, but were not informing staff why practice had changed. During our recent inspection, we found staff were able to tell us about incidents that had occurred and learning from these.

The service used internal communication methods to inform staff of learning and changes to practice. Monthly maternity clinical governance reports were distributed (emailed directly) to staff and showed the number, location, severity of incidents, and incident themes. Comparative data was presented from previous months was to map incident numbers, locations and themes over time.

Where relevant, the governance report highlighted discrepancies between incident reports and maternity dashboard figures, and noted these as missed opportunities for learning and good practice to be shared. It was conceded in the report that some incidents may have been reported under other categories.

We saw evidence of specific learning events and investigations posted in clinical areas for staff to review. The service used a trust-wide monthly newsletter and weekly safety brief to inform staff of learning and changes to practice, and to keep staff informed of risks which faced the directorate. We observed the safety brief displayed in clinical areas. Staff we spoke with across the service told us that incidents and learning were also discussed at the labour ward forum, team meetings, and handovers.

The Duty of Candour (DoC) is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm. Duty of candour was evidenced in the completed serious incident investigation and meeting minutes we reviewed. The staff we spoke with at the midwifery-led unit said they were open and honest with women if things went wrong.

**Safety thermometer**

The service submitted data to the national maternity safety thermometer. The tool allows teams to take a temperature check on harm and records the number of harms associated with maternity care, but also records the proportion of mothers who have experienced ‘harm free’ care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This is a point of care survey that is carried out on a single day each month on 100% of postnatal mothers and babies. Data are collected from postnatal wards, women’s homes and community postnatal clinics.

Maternity safety thermometer data was presented for all maternity settings at the trust, hospital care, midwifery-led unit care, and community care.

However, when we reviewed the data, we found significant gaps in reporting for midwifery-led care and community care; sometimes in excess of six months. This might be attributed to the low number of women available for participation in these services on the days surveys were conducted.

We therefore do not report on safety thermometer data for this location.

The maternity service submitted data to the maternity safety thermometer, but did not routinely use the tool to support safety and improvement; as they considered more accurate and informed
tools exited which better supported this. The service considered the tool unrepresentative of actual performance. This, they said, was due to significant restrictions on the data, including snapshot data and low numbers which are not representative of all service users, and inconsistency in data collection methodologies across organisations. The service instead said they valued maternity dashboard, FFT and patient surveys (which they considered provided richer and more representative data), alongside themes from complaints, incidents, and serious incidents to inform an accurate picture of the quality of the service. We saw evidence that this evidence drove improvements. The service noted there is currently a national review of the safety thermometer as to its value as an improvement tool.

Is the service effective?

Evidence-based care and treatment

The delivery of care and treatment provided to women was based on guidance issued by professional and expert bodies. This included the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence based practice.

Policies and procedures were available on the trust’s intranet and were approved by the clinical governance group. Staff told us that policies and guidance could be accessed on the trust intranet, which they found easy to navigate. All the electronic policies and guidance we reviewed across the service were found to be current and reflected quality standards and national guidance.

The minutes of Maternity Governance Meeting minutes (December 2017 to June 2018) showed monitoring and review of controlled documents within the service.

The manually held policies and clinical guidelines we saw on site were seen to be within date with version control.

At our previous inspection in May 2017, we found a lack of additional audit activity following the amalgamation of services on the Pinderfields site.

At our recent inspection, we saw that a quality data and audit midwife had been recruited in April 2018. Prior to this, the post had been vacant for more than 12 months. The quality data and audit midwife was responsible for producing the annual maternity audit programme, in conjunction with the governance midwife. In addition, for allocating and supporting staff with clinical audit, to ensure the plan was delivered within timescale.

We reviewed an update to the clinical audit programme and action plan for obstetric and maternity services (dated to July 2018). We saw several local audits marked as ongoing that had surpassed dates of estimated completion. In some cases, audits had been significantly delayed; for example, the Antenatal Risk Assessment (level 1) audit was due to be completed by March 2017.

The governance midwife and IHoM informed us that the quality data and audit midwife had made good progress with backlogs since their appointment, and had prioritised activities for completion. We saw evidence of this, and noted that national audit programmes were on-track overall. However, we saw several local audits marked as ongoing that had surpassed dates of estimated completion. For example, the antenatal risk assessment (level 1) audit was due to be completed by March 2017. We also learned that the service had not conducted a MEWS audit in the 12 months prior to our inspection. The service told us this was ongoing and later provided evidence of completion in the form of preliminary data (August 2018); although this had not been quality assured. We could not find evidence in the audit programme that a ‘fresh eyes’ audit had been conducted in 2017 to 2018. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). We also could not see that a ‘swab count’ audit had been conducted in 2017 to 2018; but did see that a ‘swab count’ audit was planned for 2018 to 2019.
(and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. The service reported that it did not undertake pain audits.

The service reported that audit activities were on-track to be completed within adjusted timescales. We saw audit activity was entered on the maternity risk register and this was appropriately monitored and reviewed. However, we noted significant delays with the local maternity audit programme overall.

**Nutrition and hydration**

The service had a current infant feeding policy, based on UNICEF UK Baby Friendly Initiative standards for maternity and neonatal (UNICEF, 2014), relevant NICE guidelines (NICE, 2008; NICE, 2017), and the Healthy Child Programme (DOH, 2009).

The trust had implemented United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards, and had achieved full accreditation.

Midwives were required to attend a one-day UNICEF Breastfeeding and Relationship building course within six months of their start date.

There was an infant feeding coordinator at the trust. Their role included training staff, division of frenulotomy (tongue-tie) clinics, and supporting breastfeeding mothers on the postnatal ward and in the community.

Since our last inspection in May 2017, the service had increased their breastfeeding initiation target from 60% to 70%. Maternity dashboard data for Friarwood birth centre showed that from July 2017 to June 2018, the proportion of women who had commenced breast feeding within 48 hours of delivery was 73.1% at the location. This was above the trust’s target.

Women who chose to formula feed their baby were asked to bring their own powered formula and bottles into the unit. Women were supported to make their formula correctly throughout their stay.

The service worked with community services and public health to provide continuity of support for breastfeeding once women had left the hospital. The trust supported local, volunteer-run, weekly, breastfeeding cafes, which women could attend for support and advice.

Refreshment facilities were available in antenatal clinic waiting area. Women and their families were able to have light meals and snacks during their time on the birth centre.

**Pain relief**

The birthing centre had had two birthing pools and equipment to support active labour; such as active birthing couches, birthing balls, and TENS machines.

Pharmacological pain relief options included diamorphine, meptazinol (meptid), and pethidine. Women attending the birthing centre who requested epidural analgesia were transferred to the labour ward at Pinderfields Hospital.

The service did not actively promote alternative therapies, for example, hypnobirthing. However, we were told they supported women who chose this method of pain relief; and we saw patient information leaflets on display that described the potential benefits of different holistic pain relief methods.
Patient outcomes

From July 2017 to June 2018, maternity dashboard data for Friarwood birth centre showed the proportion of instrumental deliveries was 0%.

Over the same period, the proportion of non-interventional (normal) deliveries was 100%.

Within this timeframe, 23.1% of deliveries at the location were water births.

From July 2017 to June 2018, maternity dashboard data for Friarwood birth centre showed the proportion of pre-term babies delivered before 37 weeks gestation was 0.0%.

Over the same period, maternity dashboard data for Friarwood birth centre showed the proportion of babies with low birth weight (under 2200g) born at term was 0.0%.

Maternity active outlier alerts

As of May 2018, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the MBRRACE audit. The latest MBRRACE report (June 2018) showed their stabilised and risk-adjusted extended stillbirth rate (per 1,000 births) was 3.78. This was similar to the average for the comparator group rate of 3.74.

Their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.08. This was slightly higher than the average for the comparator group rate of 4.95.

MBRRACE data was based on information collected from January 2016 to December 2016 (and published in the most recent MBRRACE report available at the time of inspection).

(Source: MBRRACE UK)

The service had a MBRRACE Perinatal Confidential Enquiry action plan (2017). The action plan showed the service was compliant against all applicable recommendations, with the exception of one. The action plan detailed that the home birth guideline was currently being updated to include practical guidance around resuscitation of a baby born in extremis and out of hours in their service; with deadline set for August 2018.

The service completed a gap analysis against the MBRRACE Saving Lives, Improving Mothers’ Care UK report in December 2017. The associated action plan listed 28 actions required to achieve compliance. The service was partially or non-compliant with respect to approximately half of the recommendations listed. Actions to achieve compliance were assigned a lead, and completion date. Outstanding actions were due to be completed between September 2018 and December 2018.

The service had completed an Each Baby Counts Recommendations gap analysis, and had produced an associated action plan (October 2017). The action plan detailed 18 recommendations, of which 17 were completed. An outstanding recommendation, to employ a ‘fresh ears’ approach to intermittent auscultation, was under consideration and the service was in discussion with other trust’s as to the approach to take. A completion date of October 2018 had been set for the outstanding item.

The Maternity Services Still Birth Group Meeting minutes for July 2018 reported that the trust were fully compliant with the Saving Babies Lives Stillbirth Bundle; a care bundle for stillbirth prevention, through improved antenatal recognition of foetal growth restriction.

From July 2017 to June 2018, maternity dashboard data for Friarwood birth centre showed no stillbirths had occurred at the location.
Maternity dashboard data for Friarwood birth centre showed that from July 2017 to June 2018, the proportion of normal deliveries resulting in a 3rd or 4th degree tear was 2.8%. The maternity dashboard did not display a trust target for 3rd or 4th degree tears. However, rates appeared slightly higher than Yorkshire and Humber averages for the period April 2017 to December 2017 (the most recent data available at the time of inspection), which ranged from 2.1% to 2.4% per quarter. Nevertheless, we saw that there had been no third or fourth degree tears at the service for five of the months between July 2017 to June 2018.

Maternity dashboard data for location showed that from July 2017 to June 2018, the proportion of women who experienced a postpartum haemorrhage (PPH) of more than 1500mls at the birth centre was 0.9%. Over the same period, the proportion of women who experienced a PPH of more than 2500mls was 0.0%. The maternity dashboard did not display a trust target for PPHs. However, rates were much better than Yorkshire and Humber averages between April 2017 to December 2017, which ranged from 5.7% to 6.6% per quarter (PPH more than 1500mls) and 2.4% to 4.6% (PPH more than 2500mls).

From October 2017 to June 2018, there were 60 transfers from the birthing centre to the labour ward at Pinderfields Hospital. We were unable to calculate the proportion of women transferred, as the service had changed their data collection and recording methods in October 2017, to monitor transfers by site.

Data provided by the trust showed the stage of pregnancy (antenatal, intrapartum, postnatal) at which the transfer took place, and reasons for transfer.

Data showed that of the 60 transfers, 22% (n13) were antenatal transfers, 53% (n32) were intrapartum transfers, and 25% (n15) were postnatal transfers. Of the 32 intrapartum transfers, most were recorded against failure to progress in the first stage (n7, 22%) or second stage (n6, 19%) of labour, or identification of fetal heart abnormalities (n5, 16%).

Staff told us that transfers had been clinically appropriate and that there had been no occurrences of women inappropriately attending the birthing centre. It was trust policy to report any inappropriate transfers or attendances as incidents using the Datix incident reporting system.

For intrapartum transfers, the average time from a call being made for ambulance transfer to ambulance arrival at the birth centre was 22 minutes. The average time from the birth centre to arrival at Pinderfields Hospital was 17 minutes.

We were told there was ongoing review and monitoring of trends in transfer rates, and any practice issues highlighted would be addressed by the consultant midwife and raised in women’s clinical governance, quality, and performance meeting agendas.

From July 2017 to June 2018 there were 98 women booked for home births with the Pontefract and Wakefield community teams. Of these, 33 women (34%) were transferred to Pinderfields Hospital for delivery.

**Competent staff**

Matrons and managers monitored staff training monthly. They allocated staff to training and used the appraisal system to identify the need for additional training.

**Appraisal rates**

Following our inspection, the trust provided appraisal data for staff within maternity services. Data showed that as of June 2018, 100% (all) of 417 eligible maternity services staff at the trust had received an appraisal.
Following the change in legislation, (April 2017) the statutory role of the supervisor of midwifery (SOM) no longer existed. The service had implemented a role called midwifery advisors. Midwifery advisors were on call for 24 hours for independent advice and support as required.

Midwifery staff we spoke did not report any problems accessing midwifery advisors for supervision, guidance and advice. However, we did see that the ratio of senior midwives to midwives at the trust was low compared to the national average. From January 2017 to December 2017, the ratio of senior midwives to midwives at the trust was 0.13; this was considerably lower the national average of 0.24.

A ‘Six Monthly Review of the Midwifery Staffing Establishment October 2017- March 2018’ paper was submitted to the Trust Board in June 2018. The paper outlined that the service is currently working on a project to develop the midwifery support workers (health care assistants) skills set. This will involve a new job description, competency packages and reconfiguration of allocation into certain clinical areas to support the delivery of safe care.

The paper detailed that skill mixing is essential to ensure midwives are effectively deployed and supported by other colleagues, such as maternity support workers who are giving clinical care. In addition, that current data and the consensus of expert midwifery opinion is that a 90% to 10% split between midwives and non-midwifery support staff allows for flexible and sustainable services.

Band 5 staff had a structured programme of rotation as part of their preceptorship programme. The midwifery preceptorship programme provided key consolidation areas for all midwives to become confident in implementing their role in the rotation programme. The course was over a full two year period. Staff spent six months on the antenatal and postnatal wards, six months at the delivery suite, three months in the along-side birth centre (all at Pinderfields Hospital), and nine months in a community placement in any of the three trust locations.

To maintain skills and confidence, band 6 ‘core’ midwives were rotated on a short ‘up-date rotation’ for three months into the labour suite. This followed from staff feedback, that being called to the main obstetric site caused some apprehension.

Community midwives rotated into the labour suite for two weeks each year; to help keep up their competencies. This commenced in June 2018. We saw that midwives from each of the three community teams at the trust had either had staff rotate into the service, or were rostered to do so.

Senior staff reported that any member of maternity staff can request to rotate to another area, and this was facilitated by the Maternity Matron.

Four midwives working at Friarwood birth centre were new born and infant physical examination (NIPE) trained. In addition, eight midwives in the Pontefract community team were NIPE trained.

The trust was unable to provide bereavement training completion rates for maternity services staff. They reported that processes were in place to ensure the data is captured going forward, as part of the service’s mandatory training for midwives’ update. We saw evidence of a programme of upcoming training sessions, and a schedule for all midwifery and nursing staff in the service to be trained in the next three years. Bi-annual maternity specific study days were also available (see Caring, emotional support section).

**Multidisciplinary working**

There was a formalised structure of meetings in place to enable multidisciplinary team working. These included monthly maternity governance meetings and perinatal mortality and morbidity meetings.
We observed good multidisciplinary working in clinical areas. All staff, including those in different teams and services, were involved in assessing, planning and delivering women’s care and treatment.

The service participated in regional and local multidisciplinary team networks, in areas such as fetal medicine.

We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.

Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists, and pharmacy.

Midwives at the hospital and in the community worked closely with the trust safeguarding team, GPs, and social care services, when dealing with safeguarding concerns or child protection risks.

Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals when needed.

There were clear processes in place for multidisciplinary working in the event of maternal transfer by ambulance from the birth centre or homebirth to hospital.

Emergency training (YMET) and skills and drills training included multidisciplinary staff.

In addition, mandatory bereavement training study days were available to all maternity, neonatal, gynaecology and obstetrics staff. Staff from A&E were recently invited to attend the sessions, to assist them with women attending with a fetal loss within their department.

Seven-day services

The birth centre offered a 24/7, seven days a week service.

Antenatal clinics and the antenatal day unit were available five days per week, Monday to Friday, during working hours.

On-call community midwives were available twenty-four hours a day, seven days a week.

Health promotion

There was a lead midwife for public health at the trust.

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in infant feeding, substance misuse, diabetes, and perinatal mental health.

Maternity dashboard data for Friarwood birth centre showed that from July 2017 to June 2018, the proportion of women smoking at time of booking was 24.3%. The proportion of women smoking at time of delivery was 19.2%; which was above the trust target of 18.3% and worse than most recently available regional averages.

Yorkshire and Humber maternity dashboard data for the period April 2017 to December 2017 showed the average proportion of women smoking at time of delivery ranged from 13.4% to 13.6% per quarter (mean 13.5%).

A smoking cessation lead midwife had recently been appointed to improve smoking at time of delivery rates for pregnant women at the trust. The role included empowering staff to assist
women to stop smoking during pregnancy. We saw that new pathways for smoking in pregnancy had been ratified at the February 2018 maternity governance meeting.

A range of health promotion patient information leaflets was available at the service. These included, immunisation in pregnancy guidance by Public Health England, ‘Why weight in pregnancy matters’, UNICEF ‘Building a happy baby: A guide for parents’, and a guide for management of long term health conditions in pregnancy. A selection of smoking cessation material was also on display.

Pregnant women were able to take advantage of 10 free (‘pregnant tums and new mums’) swimming sessions, at various locations across in the local area.

Information about antenatal classes and support groups were also displayed. These included a free six-session ‘Nurturing parents – preparation for parenthood’ course.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 95% for completion of level 1 (core) Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) mandatory training, and 85% for level 2 (role specific) MCA and DoLS mandatory training.

**Trust level**

A breakdown of compliance for MCA and DoLS mandatory training courses for applicable staff in maternity services at the trust as of June 2018 were provided.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA and DoLS Level 1</td>
<td>449</td>
<td>450</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>MCA and DoLS Level 2</td>
<td>186</td>
<td>251</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>MCA and DoLS Level 3</td>
<td>26</td>
<td>44</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the completion target for MCA and DoLS Level 1 training (100%), but did not meet completion targets for MCA and DoLS Level 2 (74%) and Level 3 (59%) training.

Women we spoke with confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.

Staff we spoke with clearly articulated consent procedures, and the use of Gillick competency for consent of patients under the age of 16 years.

We saw that ‘Consent to examination or treatment’ patient information leaflets were available in clinical areas.
Compassionate care

Friends and Family test performance

Friends and family test performance (antenatal), The Mid Yorkshire Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

The trust performance dropped slightly to 92% in September 2017, compared to the England average of 97%. The trust performance for antenatal in the latest month, March 2018 was 97%, the same as the England average, 97%.

Friends and family test performance (birth), The Mid Yorkshire Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Each pair of lines below is for each month, the top number is the England Score, the bottom number is the Trust Score.

The trust performance (% recommended) for birth services in the latest month, March 2018 was 100%, compared to the England average of 97%.

Friends and family test performance (postnatal community), The Mid Yorkshire Hospitals NHS Trust
From March 2017 to March 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of maternity services 2017

The trust performed similar other trusts for 12 out of 16 questions in the CQC maternity survey 2017; two questions were not applicable to responses gained about maternity services at the trust.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.59</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.08</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.50</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.94</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.08</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.20</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.71</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.74</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.40</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.12</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.97</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the</td>
<td>7.61</td>
<td>About the same</td>
</tr>
</tbody>
</table>
The trust performed better on care during labour and birth, when spoken to in a way they could understand.

The trust performed worse than other trusts for the care patients received in hospital after the birth of their baby, been treated with kindness and understanding.

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

In the CQC maternity survey, the trust performed worse than most other trusts for treating women with kindness and understanding in hospital after the birth of their baby.

A recent survey of maternity service users was commissioned by the CCG in conjunction with the Maternity Voices Partnership (MVP) group. Data was gathered from 502 women in early 2018. Membership criteria for the MVP included having given birth at the trust in the last four years. The survey focussed on postnatal care, but many women shared their experiences of their entire maternity journey.

Throughout the survey, there were many positive comments about staff, care and feeding support received whilst in hospital. For example, when asked what was good about their experience, comments included, “1:1 care form midwife”, “fantastic /supportive / friendly care from midwife” and “kept well informed”.

In addition, quantitative data was largely positive. For example, on a scale of 1 to 10 with 10 being excellent, 75% of women rated their maternity experience overall as 6 or above; and 26% rated it as a 10.

However, there were also a number of negative comments (n62) around staff attitude, consistency of staff, quality of care, feeding support, lack of information and support.

The survey related to the service as a whole, and findings cannot be reliably assigned to a particular location. In addition, we were unable to gauge the extent to which women’s expressed concerns captured experiences of care since our last inspection of the service.

We noted the comparatively low number of formal complaints (n3) received about services at the location from April 2017 to February 2018, and the relatively high number of formal compliments (n32) received (see Responsive, Learning from complaints and concerns section).

Women and their partners we spoke with during our inspection of the birth centre were positive about the care they received.

During our inspection we observed staff interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.

Staff we spoke with told us they were positive about providing good quality and compassionate care to women.

On the birthing suite notice boards we saw thank you cards and letters from women.
Emotional support

There were guidelines and care pathways in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.

The trust had a named maternity bereavement midwife. In addition to providing bereavement training, the role included providing advice, training and support to staff caring for and supporting bereaved parents within the service.

A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss. The bereavement midwife worked collaboratively with the consultant lead, to ensure women received appropriate support following pregnancy loss.

The trust was unable to provide bereavement training completion rates for maternity services staff. They reported that processes were in place to ensure the data is captured going forward, as part of the service’s mandatory training for midwives’ update.

The service reported that, from June 2018, the maternity bereavement training session had been included within the midwives mandatory training update (with 25 training spaces offered every month). As recommended by Yorkshire & Humber and Stillbirth and Neonatal Death Support (SaNDS), training was required every three years. The service said that the training programme and schedule would ensure that all midwifery and nursing staff were up to date with the now mandatory requirement within the next year.

In addition to mandatory bereavement training, staff were able to attend bespoke maternity bereavement study days; which took place every six months. At the time of inspection, we saw one study day had taken place so far in 2018, with a further two planned later in the year. Study days could accommodate 15 to 20 participants, and were available to all maternity, neonatal, gynaecology and obstetrics staff. Staff from A&E were recently invited to attend the sessions, to assist them with women attending with a fetal loss within their department.

Senior staff told us that funding was available for staff wishing to attend further external training, that included obtaining consent for post-mortem examinations.

The multi-faith chaplaincy service offered bereavement support to those who have lost a baby through miscarriage, stillbirth or neonatal death; and had a 24-hour on-call service including out-of-hours cover for emergencies via hospital switchboards.

There was a perinatal lead midwife in the service, who had been appointed to improve services for vulnerable women and those with perinatal mental health concerns.

Staff said perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.

A survey of maternity service users was commissioned by the CCG in conjunction with the Maternity Voices Partnership (MVP) group (see Compassionate care section, above). The summary information received noted negative comments that included those around lack of support. However, there was no evidence to suggest that comments related to services provided at this location.

The service scored similar to other trusts for questions in the 2017 CQC maternity survey that related to support. For example, for the question, “at the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?”.

During our recent inspection, two women we spoke with and their partners told us they felt supported by the staff. One of the couples also told us that, ‘Nothing was too much trouble’ and they were encouraged to ask questions.
Birth centre staff we spoke with during our inspection were proud of the level of emotional support offered by the service.

**Understanding and involvement of patients and those close to them**

Women were given the opportunity of making an informed choice about all available birth settings appropriate and safe for their clinical need and risk.

There were guidelines for standalone and along-side birth centres, and for homebirths. These provided guidance on which women were eligible for midwifery led care, risk assessments and record keeping, and actions to take should the woman develop risk factors requiring obstetric opinion.

Lower risk women were able to deliver in any of the birthing suites provided by the service, and in their own homes; and could also opt to deliver at the labour ward if they so wished.

There was a Maternity Voices Partnership (MVP) group in place at the trust. Women who are pregnant or have had a baby in the last four years can meet together with staff from the maternity services. This included midwives, obstetricians, breast feeding peer supporters, and staff from the Clinical Commissioning Group (CCG) who commission services on behalf of local people.

Over the past year the MPV had discussed the re-configuration of maternity services and received presentations from Homestart family charity, PANDAS (Pre and Postnatal Depression Advice and Support) and the trust Matron for Children who discussed care from health visitors and wider children’s services.

A survey of maternity service users was commissioned by the CCG in conjunction with the MPV group (see Compassionate care section). The summary information received noted negative comments that included those around lack of information.

Data summaries from the survey suggested that women’s negative comments and perceptions predominantly related to hospital-based services at Pinderfields Hospital. However, the survey related to the service as a whole, and findings cannot be reliably assigned to a particular location.

In the CQC maternity survey 2017, maternity services at the trust were among the best performing for speaking to women in a way they could understand during labour and birth. Responses to several other questions pertaining to offering information and inclusion in decision-making were similar to other trusts.

During our recent inspection, we spoke with one couple in the antenatal clinic. They told us they were asked where they would like to have their baby and supported with their options of where they wished to go.

From February to April 2018, data from ‘Plus 5’ responses suggested women using antenatal and birth services at the trust experienced good understanding of and involvement in their care. For example, women were asked if they were always given time to ask questions or discuss pregnancy in antenatal services, and an average of 93% agreed they had. Over the same period, 93% to 95% agreed they were always spoken to in an understandable way. In labour and birth services, 93% to 95% of women agreed that they were always involved in decisions about their care, and 98% to 100% agreed they always had concerns raised taken seriously.

Following CCG and MVP maternity survey feedback, the trust’s maternity service have planned an ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. The event will bring together new mothers and staff with the aim of improving the experience of women using its maternity services. Senior staff also told us that findings from the ‘always event’ workshop would be used to refresh the maternity services patient experience action plan.
Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From June 2016 to December 2017 the bed occupancy levels for maternity were generally higher than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

From July 2017 to June 2018, there were 198 deliveries were at the Friarwood birth centre.

Data provided by the trust showed from July 2017 to June 2018 the average bed occupancy rate at the birth centre was 6%. Data followed DoH (KH03) definitions, which means an occupied bed day is defined as one which is occupied at midnight on the day in question.

The maternity service at Pontefract provided midwifery-led care via antenatal clinics and an antenatal day unit, and a stand-alone birthing centre. The service had consultant-led clinics, so women who required obstetric review could receive care closer to home.

The premises and facilities were appropriate for the services provided there.

Women whose pregnancies were low-risk were able to choose to deliver at home, in a stand-alone or alongside midwifery-led birthing centre, or in the labour ward at Pinderfields Hospital.

Partners were encouraged to stay in the birthing centre with mothers and babies following delivery, until discharge. There was a postnatal room with a double bed for mothers and their partners.
Community-based maternity services were provided from a number of locations within the area; predominantly in GPs’ surgeries, children’s centres, and women’s own homes.

Meeting people’s individual needs

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in safeguarding, perinatal mental health, bereavement, diabetes, twins (multiple pregnancy), and infant feeding.

The service also employed a teenage pregnancy midwife, who specialised in supporting pregnant women under 20 years of age.

The trust offered a range of spiritual and holistic healthcare services at each site. The Trust’s chaplaincy team offered a point of contact with the appropriate faith community, and there was a hospital chapel and prayer room at the location. The chaplaincy service was available to visit wards/units to meet with patients, carers, and staff; and an out of hours service was available.

Funeral options were offered within maternity services following a pregnancy loss, and the trust had a protocol to offer joint cremation or burial for babies/foetuses lost up to 24 weeks gestation. An allowance was made for Islamic communities or any other individual who choose to have individual burial, if they so wished.

Face-to-face foreign language interpretation services were provided by Kirklees Council. Telephone based interpreting services were provided by ‘BigWord’; who also provided translations of written documents into either audio or written format. British Sign Language (BSL) services were also available.

We saw several maternity service patient information leaflets were available in a variety of languages on the trust’s internet pages.

The trust had been working with an external company to establish feedback mechanisms which supported access for harder to reach groups. FFT cards were available in large print on yellow card and easy to read versions. A freephone interpretation service could be accessed for feedback in many languages and translated versions of the survey were also available via the trust website. Interpreters, accessed via the trust, had been given written information to support the verbal translation of feedback from patients they saw.

The trust access group met quarterly with stakeholders with disabilities to identify and improve services. Specialist learning disabilities nurses were available at the trust, that led a learning disability patient experience group.

Access and flow

Maternity dashboard data for the location showed that from July 2017 to June 2018, 95.4% of initial antenatal bookings were undertaken before 13 weeks. This was above the trust target of 90%.

However, staff in antenatal clinics across maternity service sites (including at this location) told us that they experienced difficulty offering women follow-on appointments due to increased demand and limited capacity. During our inspection, staff at Pinderfields Hospital showed us a capacity list of over 150 women waiting to be booked for antenatal follow-up appointments across the service, and we saw no additional slots were currently available until October 2018.

Senior management we spoke with recognised the high demand for antenatal appointments at the location, and across maternity service sites. As of April 2018, three entries on the maternity risk
register identified moderate to high risks in relation to antenatal clinic capacity, the availability and capacity of obstetric staff for clinics/review, and increased demand for scan requests.

The Maternity Clinical Governance meeting action log (June 2018) identified concerns around midwives reviewing high risk scans and making plans on when to bring women back to clinic, and midwives working and making decisions above and beyond their role at Pinderfields Hospital (entry dated to April 2018). The entry noted it was also not the role of the on-call team. It was stated that there was not enough consultant/doctor capacity in the antenatal clinic for all women to be seen. It was identified that the day unit needed a designated doctor to review these women and a dedicated clinic time for women being referred for repeat scans. Entries dated to May 2018 and June detailed the issue had been escalated, a standard operating procedure prepared, and these would be discussed an antenatal clinic summit.

The management team and senior staff described the implementation of several actions to try and improve access and flow across the antenatal service (which were noted on relevant maternity risk register entries). These included training two midwifery sonographers, extending the antenatal day unit opening hours at the Pinderfields site, development of a midwifery care pathway for scanning and scan review, and an antenatal booking and risk assessment audit (the latter is due to be completed August 2018).

The management team explained flexibility had been introduced within the antenatal service, by directing low risk women to midwifery-led day units (at Pontefract and Dewsbury) where possible. On-call obstetric consultants were able to review CTG results remotely, and we saw evidence of this during our visit. However, some midwifery staff we spoke with described delays in obtaining medical review, and sometimes felt they were working beyond their role.

There was an antenatal clinic task and finish group in place at the service, and we reviewed an action log compiled by the group dated to July 2018. The log detailed 39 actions, 32 of which were completed, and five were in progress. Ongoing actions included setting up a sub-group to agree a diabetic pathway and improvements to the antenatal clinic booking system. We saw that outstanding actions were due to be completed by August to September 2018.

An antenatal clinic summit was being organised for September 2018 to review ideas for rapid resolution across the antenatal service.

Information received from the trust following the inspection showed that the concerns with insufficient antenatal clinic capacity to meet the volume of patients was due to insufficient medical staff to cover the antenatal clinics. This resulted in 150 women at the time of inspection and across the trust, waiting for an antenatal appointment. Antenatal clinic capacity was recorded on the trust risk register and identified as a priority.

From the 1st August 2018, the situation improved with the new intake of doctors. The gaps on the rotas had reduced and extra capacity clinics had been opened to accommodate the volume of patients. This meant that although there were 28 patients awaiting an appointment (as of mid-September 2018), processes were in place for these patients to be seen within the required timeframe. We saw that the ‘capacity list’ was monitored on a daily basis. Patients who could not be booked for a further appointment due to clinic capacity, were escalated to the antenatal clinic lead consultant. They reviewed the individual patient records and agree a suitable date for the women to be seen; without impact to their care. As of September 2018, we were assured that all patients had been seen within the appropriate timescale. However, should this not be possible, that a formal risk assessment would be undertaken and documented. This had not been required to date.

The service had an Escalation and Closure Policy (review date August 2019). The policy provided guidance for maternity staff about clinical decision making and required actions in the event of a closure. This is a situation where capacity and complexity of workload present challenges in the delivery of a safe maternity service for women and their babies, and the service must be closed to
new patients. It stated that closure would only be considered when all other potential solutions were exhausted.

The trust provided data that showed the number of closures at the location. Closure data for July 2017 to June 2018 showed Friarwood birth centre had closed on nine separate occasions; all between December 2017 and June 2018. Closures ranged from 12 to 84 hours on each occasion.

Following the maternity service escalation policy, data suggested closures had occurred to meet maternity service demand at Pinderfields Hospital.

Learning from complaints and concerns

There was a trust complaints policy and procedure in place, which staff we spoke with were aware of.

We observed patient advice and liaison service (PALS) information leaflets on display in the areas we visited.

We also saw trust information leaflets on display in the waiting area about how to make a comment, compliment or complaint.

Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform their manager.

Summary of complaints

From April 2017 to February 2018, there were 88 complaints about maternity services. The trust took an average of 20.4 days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be closed within 30 days.

Of the 88 complaints received about maternity services at the trust, only 3 related to maternity services at the location. No complaints were received about community midwifery services at the location.

<table>
<thead>
<tr>
<th>Location</th>
<th>Antenatal Clinics/Day Unit</th>
<th>Community Midwives</th>
<th>Friarwood Birth Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pontefract Hospital</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of compliments made to the trust

From April 2017 to February 2018, there were 127 compliments were received and recorded about maternity services at the trust.

Of these, 32 (25%) were made in relation to maternity services at the location. Most of the 32 compliments received were about care provided in the birth centre (88%).

<table>
<thead>
<tr>
<th>Location</th>
<th>Antenatal Day Unit</th>
<th>Community Midwives</th>
<th>Friarwood Birth Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pontefract Hospital</td>
<td>2</td>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We saw evidence of learning from complaints and concerns. In response to FFT feedback, each inpatient ward area across the service had produced a ‘welcome to the ward’ leaflet that outlined
meal times, discharge procedures, telephone numbers and ward information (completed October 2017 and updated March 2018). We saw these on display during our visit.

There was a Maternity services patient experience action plan 2018/2019. The plan listed 17 actions informed by patient feedback, designed to improve patient experience. We saw 14 actions had been completed, one action had been removed, and two actions were ongoing.

Following CCG and MVP maternity survey feedback, the service had planned an ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. Senior staff also told us that findings from the ‘always event’ workshop would be used to refresh the maternity services patient experience action plan.

Is the service well-led?

Leadership

Maternity services formed part of the Women’s Services, in the Families Services, Clinical Support and Facilities division. A head of clinical service for obstetrics and gynaecology, a patient services manager, and an interim head of midwifery (IHOM) led the maternity service.

The senior management team had changed since our previous inspection in May 2017, and was relatively new. At the time of our most recent inspection, the head of clinical services had been in post for eight months, and the IHOM had been in post for seven months.

The management team described that had started to make ‘in roads’ into the service, and to implement the changes necessary to improve quality of care. During our inspection, we observed cohesive team working; with support offered from clinical leads and the deputy director of operations (Families and Clinical Support Services).

There was a matron for community and outpatients, who had day to day responsibility for the service. At the location, there was a midwife (band seven manager) responsible for the birth centre and a midwife (band seven manager) responsible for antenatal services.

There was a band seven community midwifery team leader who was responsible for the Pontefract community team.

Midwives reported they were supported by their managers, who would undertake clinical shifts to support teams and keep their competencies up to date.

Student midwives at the location reported that they felt supported by managers, and their colleagues.

Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme and through one-to-one meetings with managers.

Vision and strategy

The trust’s vision was “to achieve an excellent patient experience each and every time”.

There was a maternity governance and risk management pathway (review date July 2020); which stated that the aim of the maternity service was “to provide all our women and babies with high quality care that is delivered in a safe environment”.

The trust had a maternity service improvement plan (March 2018), designed around high-level themes the service aspired to achieve. Themes centred on building strong leadership, building the capability and skills of staff, sharing progress and lessons learnt, and improving data capture and
knowledge. A multidisciplinary meeting identified five focus areas to improve safety within the maternity service; leadership and teamwork, staff training and development, clinical governance, perinatal mental health, and ensuring quality maternity data. There was an action plan for each core focus area, which detailed the recommendation, actions implemented to achieve it, designated lead, and evidence of implementation. At the time of viewing, all but one of the actions (which was ongoing) had been completed; but during our inspection several areas of the maternity service (especially in relation to access and flow) were identified as in need of quality improvements, with no clear strategy in place to address these issues.

There was also a maternity services patient experience action plan 2018/2019. The plan listed 17 actions informed by patient feedback, designed to improve patient experience. We saw 14 actions had been completed, one action had been removed, and two actions were ongoing.

An ‘always event’ workshop was planned for September 2018, to bring together new mothers and staff with the aim of improving the experience of women using its maternity services. Senior staff told us feedback from the event would be used to revise and update the patient experience action plan.

We also saw evidence of action plans arising from engagement with maternity services staff at the trust. For example, an action log arising from a ‘little conversation’ event with community midwives earlier in the year.

Culture

The Freedom to Speak Up Guardian (FTSUG) submitted six-monthly progress reports to the trust board. In March 2018, the FTSUG report showed that from September 2017 to March 2018, the greatest number of concerns raised from one specific area came from staff within maternity services (seven), both acute and community. We saw that a concern (raised in 2017) included claims of a culture of bullying and cronyism in maternity services. Discussions had taken place between the FTSUG and the Matron and Head of Service for the area concerned.

During our inspection, the IHoM reported that at appointment, she had been given a mandate to focus on the culture within the service.

The IHoM said that she had implemented a programme of ‘little conversations’ to engage with maternity staff, and one had already taken place with community midwifery staff. Further ‘little conversations’ were planned for birth centre and labour ward staff.

The IHoM said she was approachable and accessible, and welcomed concerns from staff. During our inspection, we observed that the IHoM had visited a member of midwifery staff at another trust site to discuss their concerns.

The IHoM reported that regular meetings took place with Royal College of Midwifery union representatives, to discuss “what happens on the shop floor”.

The IHoM recognised that culture could not be changed “overnight”, but felt that “a corner had been turned”. At the time of inspection, the IHoM told us that she liaised with the FTSUG, and no concerns had been raised by maternity services staff with the guardian since March 2018.

At our recent inspection, we saw the service had implemented a number of initiatives to improve staff morale.

The service had introduced ‘My Maternity Star’ awards. These allowed staff to nominate maternity colleagues who had made positive contributions to colleagues and patients.

There was also a monthly governance newsletter (“Maternity Measured”), with a more in-depth issue issued every six months. The March 2018 issue focused on celebrating changes in the 18 months since reconfiguration of the service. The management team thanked staff for their hard
work and highlighted achievements and reasons for staff to be proud. Community team leaders and birth centre managers also submitted messages.

We observed strong team working, with specialised and multidisciplinary staff working cooperatively and with respect for each other's roles. Most staff spoke positively about the culture at the service, and were proud of the quality of care they delivered.

Some staff told us they worked across the service and at the Dewsbury District Hospital site. They positively described how they supported each other and worked as a team. They had team building across the hospitals and attended joint social events.

Some maternity service staff we spoke with during our inspection raised concerns about capacity and workload, which impacted on their perceptions of culture within the service. Concerns predominately related to antenatal service capacity (please refer to Responsive section). Staff described feeling “frustrated” about capacity and ‘bottle necks’ in the system.

**Governance**

There was a Maternity Governance and Risk Management Pathway policy document (review date July 2020). The key aims of the pathway were to develop a more dynamic approach to risk management, embed risk management systems and processes and promote a culture where risk management is everybody's business, and to clearly define roles and responsibilities for risk management and governance at a directorate level.

There was a defined governance structure. There were divisional and obstetric governance leads for the service. The service employed a full-time governance midwife who worked across sites; and a deputy governance midwife was employed two days per week. Staff were aware of their roles and responsibilities in relation to governance.

There were several layers of governance quality assurance. These included the antenatal screening and neonatal screening governance committee, the labour ward forum, maternity governance group, women’s governance group, family and clinical support services divisional governance group, trust quality committee, and trust board.

The maternity governance group met monthly to discuss, monitor and review all aspects of clinical governance. The role of the group was to provide assurance to the divisional governance group, regarding all matters relating to clinical quality and patient safety of the obstetrics and gynaecology services provided by the trust.

The obstetric governance lead and governance midwife led on serious incident root cause analysis (RCA) reports, and worked in conjunction with the matron or manager responsible for the service area.

A quality data and audit midwife had been recruited April 2018. Prior to this, the post had been vacant for more than 12 months. The quality data and audit midwife had oversight of the maternity service audit programme. The governance midwife and IHoM informed us that the quality data and audit midwife had made good progress with backlogs since their appointment, and had prioritised activities for completion. The service reported that activities were on-track to be completed within adjusted timescales. We saw audit activity was entered on the maternity risk register and this was appropriately monitored and reviewed. However, we noted significant delays with the local maternity audit programme overall.

During our inspection, we reviewed the maternity service RCA action log and found appropriate monitoring and review of actions. There were three outstanding action, but these had been appropriately monitored and an extension granted.
Management of risk, issues and performance

There was a Maternity Governance and Risk Management Pathway policy document (review date July 2020). It set out clear guidance for the reporting and monitoring of risk.

Senior staff we spoke with were comfortable escalating issues to the senior management team, and received appropriate feedback. Members of the senior management team were confident escalating issues to the head of women’s services, divisional leads, and (if necessary) directors and the trust board.

The service had a current risk register. This was a live document, comprising of a list of risks, and description summaries, in order of priority. The risk register was generated electronically from the trust’s electronic risk management system (DATIX) and reflected risks placed on the system.

All new maternity risk assessments were discussed on a monthly basis at the maternity risk register meeting and decisions made about the appropriateness of grading, and inclusion. The group also discussed any re-grading or risks which have been resolved from the risk register.

The risks of greatest concerns in relation to clinical and non-clinical issues were monitored by the divisional governance group. Risks that scored 12 and above were reported to the trust patient safety panel and the clinical executive group.

At our previous inspection of the service in May 2017, we saw that the maternity risk register contained a large number of risks, and many had a review date in the past. This led to concern that there was a lack of oversight by senior managers.

At our most recent inspection, we saw good monitoring and oversight of the risk register. Risk register entries were subdivided into risks with ongoing actions, and tolerable risks. We saw evidence of several risks that had been resolved in the past 12 to 18 months. We also saw evidence of appropriate discussion and grading of risks in recent maternity risk register meeting minutes.

The senior management team and senior governance staff were aware of risks facing the service. This included high demand for antenatal services and limited capacity across sites. The service had implemented measures to mitigate risks and try to resolve ‘bottle necks’ and increase capacity in the antenatal service, and an antenatal clinic summit was planned for later in the year (please see Responsive section). The senior management team were relatively new, and we saw they were aware of the issue and had made some headway in working to address this. However, at the time of inspection, we saw performance in this area remained limited.

We found an overview of serious incidents, incidents and complaints presented in monthly maternity clinical governance meeting minutes (December 2017 to June 2018). We also saw evidence of more in-depth review of incidents in maternity governance reports. For example, as submitted to the monthly maternity governance committee in May 2018. The report included a summary of incidents, the number, location, and severity of incidents, and incident themes. Comparative data was presented from previous months to map incident numbers, locations and themes over time. Midwifery red flag events were also detailed and thematically mapped. Root cause analyses from previous (completed) investigations were presented, alongside learning from RCAs.

There was a trust-wide maternity dashboard and location specific maternity dashboards (for Pinderfields Hospital, Pontefract Hospital, and Dewsbury and District Hospital). These were discussed at monthly maternity governance meetings. The service submitted data to the Yorkshire and Humber regional maternity dashboard. This meant the service could compare its performance against other local trusts and Yorkshire and Humber averages.

Information management
During our inspection, we saw that controlled documents (such as policies and guidelines) were within date, version controlled, and reflected current national guidance.

The service completed comprehensive bi-annual record keeping audits. At the time of inspection, the most recent report available was published December 2017. Audit results were benchmarked against previous findings and targets, and showed areas of improved compliance and areas of concern. Results were categorised using a RAG (red, amber, green) rating system. We saw that an action plan had been put in place to improve compliance. Ongoing activity to monitor changes in compliance included a random sample of eight maternity records per month at each location from January 2018, to be collated for the next record audit report.

During the inspection, we saw three separate entries on the maternity risk register relating to maternity service records; these were rated as presenting a moderate to high risk. All three entries centred around issues with the main maternity record software system. Staff we spoke with during our inspection reported the system was sometimes cumbersome to navigate, but overall, they found the system adequate.

The senior management team were acutely aware of the risks involved, and were currently reviewing options to implement a new paperless system for when the current software license expired (2019). The service had also developed a task and finish group to plan, evaluate and adopt a paperless postnatal record. We reviewed relevant risk register entries and saw that risks had been appropriately monitored and mitigated. We also saw there was an electronic maternity system action plan 2018 in place, which showed progress towards against a new digital maternity plan for the service.

**Engagement**

There was a Maternity Voices Partnership (MVP) group in place at the trust. Women who are pregnant or have had a baby in the last four years could meet together with staff from the maternity services. This included midwives, obstetricians, breast feeding peer supporters, and staff from the Clinical Commissioning Group (CCG) who commission services on behalf of local people.

Over the past year the MPV had discussed the re-configuration of maternity services and received presentations from Homestart family charity, PANDAS (Pre and Postnatal Depression Advice and Support) and the trust Matron for Children who discussed care from health visitors and wider children’s services.

The trust collated and mapped independent/externally collected patient experience data from Picker patient experience surveys and summaries, the NHS patient safety programme, and unannounced ‘walkabouts’ by the CCG. They also produced ‘Plus 5’ maternity reports, which asked questions based on feedback from an ‘always event’ held with women 2017; which had been added to FFT cards.

Following CCG and MVP maternity survey feedback, the trust’s maternity service have planned an another ‘always event’ workshop for September 2018, utilising the Institute for Health Care Improvement’s (IHI’s) Always Events Framework. The event will bring together new mothers and staff with the aim of improving the experience of women using its maternity services.

The service has also planned to implement a ‘15 steps challenge’ review of services, which will involve service users, commissioners, trust patient experience staff and an executive director. The ‘15 steps’ toolkit was developed by NHS England for MVP groups to help understand what service users experience as they access local maternity care. The toolkit aligns with NHS priorities for maternity care as outlined in the Better Births report published in 2016. The toolkit has been discussed with the local MVP group. Pending ratification at the service’s patient experience sub-committee, the service plans to roll the toolkit out in September 2018.
The trust provided us with a maternity staff communication action plan (dated to June 2018), which identified poor staff outcomes (gathered from engagement and survey activities), and actions to be taken to deliver improvements in communication. Entries identified action leads, due dates, and evidence of review and completion. We saw that a number of actions related to staff recruitment, increasing staff satisfaction, valuing staff, and progression planning. Of the 14 entries listed, nine had been completed and five had ongoing actions; and were due for review between August and November 2018.

The service had implemented a programme of “little conversations” to engage with maternity staff, and regular meetings took place between the IHoM and RCM union representatives.

Learning, continuous improvement and innovation

During our inspection, we found a lack of local audit activity to encourage continuous improvement; this had been ongoing since our last inspection of the service.

We reviewed an update to the clinical audit programme and action plan for obstetric and maternity services (dated to July 2018).

We saw that the quality data and audit midwife had made progress with backlogs since their appointment, and had prioritised activities for completion. We also noted that national audit programmes were on-track overall. However, we saw several local audits marked as ongoing that had surpassed dates of estimated completion. For example, the antenatal risk assessment (level 1) audit was due to be completed by March 2017. We also learned that the service had not conducted a MEWS audit in the 12 months prior to our inspection. The service told us this was ongoing and later provided evidence of completion in the form of preliminary data (August 2018); although this had not been quality assured. We could not find evidence in the audit programme that a ‘fresh eyes’ audit had been conducted in 2017 to 2018. An intrapartum care audit was planned for 2018 to 2019 (and was recorded to commence March 2019). We could not see that a ‘swab count’ audit had been conducted in 2017 to 2018; but did see that a ‘swab count’ audit was planned for 2018 to 2019 (and was recorded to commence June 2018). This was recorded as ongoing in the July 2018 update. The service reported that it did not undertake pain audits.

The service had successfully engaged with staff and encouraged more substantive staff to join NHS Professionals (NHSP), and had begun offering unfilled shifts as overtime to staff. Agency staff were now used as a last resort. The service had seen a significant increase in the proportion of bank (NHSP) staff used to fill unfilled shifts, and a decrease in the use of agency staff.

Outcomes from patient engagement activities had been used to inform some improvements within the service. For example, following FFT feedback, the service had introduced ‘welcome to the ward’ leaflets for each inpatient area.

We also saw evidence of continuous learning within the service. The service had commissioned an external company to undertake a thematic review of key sources of maternity feedback in late 2017. An internal co-design workshop was held to identify priorities for improvement in the areas of antenatal, labour and birth, postnatal wards and postnatal community. Five different questions relating to these priorities had been added as a monthly local survey on each of the Maternity FFT cards, at the four points of the maternity pathway.

In addition, senior staff also told us that findings from an MVP ‘always event’ and a ‘15 steps’ workshop in September 2018 would be used to refresh the maternity services improvement plan.

However, whilst we recognised significant work undertaken by the service to collate and map patient feedback, and upcoming work to engage with service users, we were concerned that patient experience action plans in place at the time of inspection were not sufficiently robust, and the service had not acted in a timely way to implement changes.
Since our last inspection, the service had implemented an MBRRACE Perinatal Confidential Enquiry action plan, MBRRACE Saving Lives, Improving Mothers’ Care action plan, and an Each Baby Counts action plan. We also found that the trust was now fully compliant with the Saving Babies Lives Stillbirth Bundle.

We saw there was a task and finish group for antenatal clinic services, and that a clinic summit had been organised to evaluate access and flow in the antenatal service. However, we were not always assured work was being delivered at a sufficient pace.
Facts and data about this service

Total number of first and follow up appointments compared to England

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from July 2017 to June 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinderfields Hospital</td>
<td>428,260</td>
</tr>
<tr>
<td>Dewsbury and District Hospital</td>
<td>186,826</td>
</tr>
<tr>
<td>Pontefract Hospital</td>
<td>172,077</td>
</tr>
<tr>
<td>The Mid Yorkshire Hospitals NHS Trust</td>
<td>1,091</td>
</tr>
<tr>
<td>This Trust</td>
<td>788,254</td>
</tr>
<tr>
<td>England</td>
<td>106,661,135</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at The Mid Yorkshire Hospitals NHS Trust from July 2017 to June 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Most staff had completed their mandatory training. Training figures supplied by the trust were trust wide and were not broken down by site. Outpatients had an overall compliance of 97% for core subject training, with a trust target of 95%. For role specific subjects, the trust target was 85%, outpatients achieved a compliance rate of 80% overall.

When we spoke with the sister for outpatients she told us that staff at Pontefract were at 98% compliance with mandatory training. Staff we spoke with told us they had no problems accessing mandatory training and that a lot of training was completed online, but that sometimes it was hard to get all the mandatory training done. One nurse was allocated to check that staff were up to date with their mandatory training and they gave reminders to staff when they were due.

The training data shows compliance for all staff in outpatients, other than medical staff. Data for medical staff would be captured under the relevant speciality.

Mandatory training completion rates

The trust set a target of 85% or 95% for completion of mandatory training, depending on the module.

Trust level

A breakdown of compliance for mandatory training courses from up to the end of June 2018 at trust level for all staff in outpatients is shown below:
## CORE SUBJECTS

<table>
<thead>
<tr>
<th>Subject Description</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Diversity Awareness - Once in Employment</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Infection Control - Every 2 Years</td>
<td>29</td>
<td>289</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 1 Theory - Every Three Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 1 - Every 3 years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Fire Safety - 1 Year</td>
<td>22</td>
<td>296</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Health and Safety Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>30</td>
<td>288</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>2</td>
<td>316</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>93</td>
<td>2769</td>
</tr>
</tbody>
</table>

## Role Specific MAST Compliance (target 85%)

### ROLE SPECIFIC SUBJECTS

<table>
<thead>
<tr>
<th>Subject Description</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Conflict Resolution - Once in Employment</td>
<td>16</td>
<td>110</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Health and Safety Level 2 - Every 2 Years</td>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Manual Handling Level 2 practical - Every Three Years</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Medicines Management Level 2 - Every Three Years</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 2 - Every 3 years</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Mental Capacity Act (including DOLS) Level 3 - Every 3 years</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Patient Safety - Every Two Years</td>
<td>20</td>
<td>122</td>
</tr>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Resuscitation Training</td>
<td>16</td>
<td>44</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 2 - 3 Years</td>
<td>16</td>
<td>44</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>119</td>
<td>471</td>
</tr>
</tbody>
</table>
Safeguarding

There were safeguarding policies and procedures in place for staff to follow, which included protocols for suspected female genital mutilation (FGM). FGM is defined by the World Health Organisation as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

Staff we spoke with could tell us the process they would follow to report any safeguarding concerns and make a referral. Staff could access advice and support from the trust safeguarding team.

Safeguarding training completion rates

The trust set a target of 85% or 95% for completion of safeguarding training, depending on the module.

Trust level

A breakdown of compliance for safeguarding training courses April 2017 to March 2018 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>(Level 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>(Level 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>(Level 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>13</td>
<td>20</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>(Level 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In outpatients the target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Data provided by the trust after our inspection showed a higher compliance rate, however this was not broken down in to the different levels of training.

| NHS|MAND|Safeguarding Adults Level 1 - 3 Years| 2 | 316 | 318 | 99% |
| NHS|MAND|Safeguarding Children Level 1 - 3 Years| 2 | 316 | 318 | 99% |

Cleanliness, infection control and hygiene

All areas we visited were visibly clean and tidy. Staff told us that it had been identified that blinds needed replacing as they could not be cleaned properly, this had been reported.

Hand gel and personal protective equipment, such as gloves, were available in all areas we visited. We saw that staff observed the arms bare below the elbows policy.

The dirty utility rooms were clean and free from clutter. We saw ‘I am clean’ stickers used to indicate that cleaning of rooms and equipment had taken place.
Rooms were cleaned weekly and before clinics. Each room had a checklist which was signed when cleaning had taken place. However, we saw that the room was not cleaned or the sheet signed to indicate cleaning had taken place if the room hadn't been used.

We saw audit results displayed in clinic areas we visited. These showed compliance with hand hygiene of 97% and compliance with bare below the elbow of 100%. Audit data for June 2018 showed average compliance for infection prevention and control of 96%.

We saw completed cleaning logs to indicate that regular cleaning of all areas had taken place.

Within the ear, nose and throat clinic there was a children’s play area, we saw cleaning logs to indicate that these toys were regularly cleaned.

At our last inspection, we found there were carpets in main outpatients. At this inspection, there were no carpets in clinical areas, only in office areas. These carpets were regularly cleaned and replaced.

Environment and equipment

Main outpatients were split in to level A and level B. Ophthalmology and ear, nose and throat (ENT) outpatients were situated in the same area as main outpatients, with their own waiting areas.

The ENT outpatient department had a children’s play area with age appropriate toys.

We saw that equipment was up to date with electronic testing.

Resuscitation equipment was available in all areas we visited. We saw that daily checks had been completed for July, up to the date of our inspection. A hypoglycaemic pack was in date and had up to date checks completed.

Fans had been placed around the department in response to concerns raised by patients that the department was too warm.

There were systems in place for the correct segregation and disposal of waste, including sharp items.

Assessing and responding to patient risk

At our last inspection, there was a backlog of patients waiting. Some of the waiting lists had been clinically validated but others hadn't been. At this inspection, staff we spoke with told us that waiting lists had been reduced and that they now had administrative and clinical validation. There was a validation team, which employed 15 validators and was in the process of appointing eight more. Each validator was responsible for a different speciality. An outpatient follow up procedure was used to minimise the clinical risk of patients who were waiting for follow up appointments. Within one month of being overdue, a follow up waiting list report was produced which was reviewed by a patient access team leader, who did an administrative validation. Any possible capacity would be identified and instructions given to booking clerks. Within two months of becoming overdue where no capacity was identified, the list of patients, by consultant, was presented to the weekly speciality control tower, who either identified where capacity could be made available or identified the patient for clinical validation by the consultant. Those plans were reviewed at the following weeks control tower meeting to ensure they had been completed. At three months of becoming overdue, the volume of patient’s overdue by three months or more was escalated to the weekly patient access control tower and patient service managers had to work with their clinical teams to put action plans in place to reduce the volume to zero. Any specialities that were off plan to deliver reduction were escalated to the Executive Access, Booking and Choice Steering Group.
However, when we asked the trust to provide evidence that all patients in the backlog had been clinically validated, they could not provide this evidence. They told us it was not possible to provide this evidence as the list changed daily, with patients removed or added to the list. It was identified on the patient administration system that seven percent of the existing backlog had been through a full administrative and clinical validation process. Thirty nine percent of patients had been added to the backlog in the last four weeks and the remaining patients were part way through the process.

In ophthalmology, at our last inspection there were backlogs in new and follow up appointments. Since then, there had been an independent external review and staff had worked to an ophthalmology improvement plan. In a newsletter to staff we saw that the backlog of follow up appointments had been reduced and there were no new patients waiting since February 2017 and no new glaucoma patients waiting since August 2017. The longest backlog patient for ophthalmology was from May 2017.

Staff told us that if a patient became unwell or deteriorated in the department they would call the hospital crash team and a doctor from the urgent treatment centre would attend. If required, an emergency ambulance would be called to transport the patient to Pinderfields Hospital. However, staff told us that the emergency buzzers in rooms were not connected and therefore did not work. Staff would shout for help if needed.

### Nurse staffing

The trust has reported their staffing numbers for outpatients below for the period from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse staffing</td>
<td>16</td>
<td>19</td>
<td>85%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

There were six qualified nurses at Pontefract hospital, they covered three outpatient areas.

The qualified nurses were supported by healthcare assistants.

Staff would cover cross site if needed.

At our last inspection, there was no matron in post. This position had been recruited to and the new matron had been in post since September 2017. When we spoke with the matron he told us that there was a workforce review in progress, which would be used to write a business case for increased staffing.

### Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 13.6% for nursing staff in outpatients. This is worse than the trust target of 9%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

There were no qualified nurse staffing vacancies at Pontefract hospital. There were 45 hours healthcare assistant vacancies.

### Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 18.5% for nursing staff in outpatients. This is worse than the trust target of 12%.
Sickness rates

From March 2017 to February 2018, the trust reported a sickness rate of 13.6% for nursing staff in outpatients. This is worse than the trust target of 4.8%. Service leads told us that sickness was closely monitored.

Medical staffing

There were no medical staff specifically for the outpatient’s service. The medical staff that held clinics were accountable to the specific divisions they worked for.

The individual specialities managed and arranged cover for their clinics.

Records

The outpatient department used a combination of written and electronic records. The paper records only contained an outcome form and patient labels. Previous history was available on the electronic record.

The department used a ‘paper light’ system, which meant that clinicians wrote up their notes following the consultation and these were then taken and scanned on to the electronic patient record.

Staff we spoke with told us they had no problems accessing patient’s medical records for the clinic. Records arrived in clinic the day before and were left with receptionist. After the receptionist has gone home the records were put in a secure room which was only accessible to staff.

Medicines

All medicines were stored securely. We saw that medicine stocks were checked weekly. All medicines were in date.

Drug cupboard keys were kept in a key safe in a store room which was locked overnight.

Fridge temperatures were monitored centrally and the service was informed if there were any deviations from the required temperature.

Prescription forms were kept in a locked cupboard and were signed in and out daily.

Incidents

The trust used an electronic incident reporting system. Staff who we spoke with were aware how to report incidents.

Learning from incidents was shared in a monthly newsletter produced by the matron. Staff could tell us about learning from incidents.

Staff we spoke with understood the principles of the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.
Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Following a review of reported incidents between April 2017 and March 2018, we found five serious incidents reported for the ophthalmology service where deterioration in vision may have been due to a delay in appointments. The reports showed a thorough investigation and immediate actions taken, including a review of the glaucoma follow up backlog to ensure those patients at greatest risk were prioritised for urgent review and the creation of additional clinics. An independent review of the service was requested. We saw that duty of candour had been adhered to and the patient’s kept fully informed.

Safety thermometer

The safety thermometer was not use in outpatients. However, outpatients did record and display hand hygiene and bare below the elbow audit results.

They also monitored the number of falls that had occurred in the department.

Is the service effective?

Evidence-based care and treatment

Staff had access to up to date policies and guidelines on the trust intranet. Patient’s care and treatment was planned and delivered in line with national guidance, including the National Institute for Health and Care Excellence (NICE).

A NICE tracker ensured that new guidance and alerts had timeframes and a reporting framework for implementation of the guidance.

Audits were done to ensure practice guidelines followed national guidance.

Nutrition and hydration

Vending machines were available for drinks and snacks.

Cardiology outpatients had a water fountain but the other areas did not. This issue had been raised by patients and the concerns had been fed back to management and the freedom to speak up guardian. A new water fountain had been purchased but staff were unsure when it was to be put in the department. At the time of our inspection, jugs of water were available for patients.

Staff would direct patients to the canteen if there was a delay in clinic.
Pain relief

Pain scores were not used in the department. Pain relief was not routinely administered in the outpatient’s department.

Patient outcomes

The outpatients service did not routinely monitor patient outcomes. This was managed by the individual specialities.

Follow-up to new rate

From February 2017 to January 2018,

- The follow-up to new rate for Pontefract Hospital was similar to the England average.

Follow-up to new rate, The Mid Yorkshire Hospitals NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff

Appraisal rates

From April 2017 to March 2018, 78% of staff within the outpatient’s department at the trust received an appraisal compared to a trust target of 85%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals who required an appraisal</th>
<th>Staff who have received an appraisal</th>
<th>Completion rate</th>
<th>Met 85% target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>71</td>
<td>56</td>
<td>78.9%</td>
<td>No</td>
</tr>
<tr>
<td>Staff group</td>
<td>Individuals who required an appraisal</td>
<td>Staff who have received an appraisal</td>
<td>Completion rate</td>
<td>Met 85% target?</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>282</td>
<td>220</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>19</td>
<td>12</td>
<td>63.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>376</td>
<td>292</td>
<td>77.7%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The appraisal rates provided by the trust were not site specific or broken down. Although the completion rate for qualified nursing staff was 63.2%, this was only seven staff members that had not had an appraisal.

Following our inspection, we were provided with updated appraisal figures, however these were not broken down by staff group. These showed a compliance rate of 95% for outpatients overall.

<table>
<thead>
<tr>
<th>Appraisal Compliance (target 85%)</th>
<th>Does not meet requirement</th>
<th>Meets requirement</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>377</td>
<td>LOCAL</td>
<td>Appraisal</td>
<td>Core</td>
<td>14</td>
</tr>
</tbody>
</table>

The sister in main outpatients told us that staff appraisal rates for Pontefract were at 100%.

All staff we spoke with us told us they had regular appraisals and these were an opportunity to discuss their development.

There were several nurse specialists that ran nurse led clinics, including epilepsy, cardiology and Parkinson’s.

New nurses and healthcare assistants had a competency document to complete. This included the rationale for a procedure and a check list. Staff would normally be observed completing a procedure around 10 to 12 times before being signed as competent. The sister in outpatients told us that the competency document was in the process of been updated.

Staff were provided with training on medical devices by the companies that provided the device.
Multidisciplinary working

The outpatient departments had a wide range of staff working together as a multidisciplinary team.

As well as medical and nursing staff there were dietitians, podiatrists, psychologists, physiotherapists and occupational therapists.

Seven-day services

Most outpatient clinics were held Monday to Friday. However, some specialities were starting to hold clinics over six days of the week.

Additional clinics were held on evenings and weekends to meet demand.

Health promotion

There were several health promotion leaflets located throughout the departments.

In the ophthalmology outpatient area, we saw information about organ and tissue donation.

A hand hygiene leaflet was available for patients to inform them of the importance of hand hygiene.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their responsibilities when obtaining consent from patients. Medical staff told us that consent forms contained a specific section around mental capacity.

Staff we spoke with told us that if they had concerns that a patient was lacking mental capacity and had attended the department unaccompanied, they would contact the mental health team for advice and support.

Staff had access to a consent policy and mental capacity policy.

Mental Capacity Act and Deprivation of Liberty training completion

Staff compliance with mental capacity act training at the end of June 2018 is shown below, this is not site specific:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>316</td>
<td>318</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

All patients we spoke with gave positive feedback. They told us that staff were caring and friendly.

We heard staff introducing themselves to patients and observed patients being treated with kindness and compassion.

Most consultations and examinations took place in closed rooms, ensuring privacy and dignity was maintained. However, a member of medical staff we spoke with told us that they had consulted in a corridor as the consulting room doors were not wide enough to fit a bariatric wheelchair through. Following the inspection, we were provided with information that showed us that there were specific treatment rooms available with wider doors, to allow for private consultations for patients in bariatric wheelchairs. The staff had identified that there could be an issue with privacy as some of the consulting rooms were near to the waiting areas, they had tried to stop any conversations being heard by using radios in the waiting areas.

Chaperones were available and signs were displayed in clinics informing patients that they could request a chaperone if required.

Friends and family test (FFT) results for May 2018 showed that 97% of patients would recommend the outpatient department to their friends and family. We saw information displayed in the main outpatient department that showed that 97.2% of patients would recommend the service. In the ophthalmology outpatients, 95% would recommend the service.

Emotional support

Clinical nurse specialists were available in several clinics, they could provide additional support to patients.

Some specialities had psychologists who provided support to patients with life changing diagnoses.

We observed staff speaking to a patient and their family in a gentle manner when they became angry due to having to wait to see the doctor. The staff gave explanations to the patient and family.

Understanding and involvement of patients and those close to them

Patient’s relatives could accompany them for their consultation.

Patients we spoke with told us they felt that they were fully informed and staff had explained things to them. We observed patients been given the opportunity to ask questions.
Is the service responsive?

Service delivery to meet the needs of local people

Evening and weekend clinics were held in response to demand. The service managed to achieve around 90% of extra clinic requests.

Patients usually had a choice of where they had their outpatient appointment. Clinics for the most common specialities, such as rheumatology, cardiology, respiratory and urology were held across the three hospital sites.

Patients could access shuttle buses between the three sites, these enabled patients travelling from other areas to attend the hospital. Transport was provided for those patients that needed it.

Some specialities had started e-consultations with general practitioners. This allowed them to discuss a patient and potentially avoid an unnecessary referral.

There was a separate children’s waiting area in the ear, nose and throat (ENT) clinic where more children would be seen.

Meeting people’s individual needs

A bariatric wheelchair was available. However, staff told us that the clinic room doors were not wide enough for the wheelchair and on occasions consultations had to take place outside of the consulting room. This had not been identified as a risk on the risk register.

Throughout the clinics we saw a leaflet for patients to complete and send to the trust if they had any communication needs. This ensured that any communication needs were highlighted and flagged up on the system. Staff we spoke with told us they knew of patients that required large print letters and they had seen patients attend with these. This ensured that the service was meeting the Accessible Information Standard (2017). The ‘Accessible Information Standard’ – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

A trust dementia nurse and learning disability nurse were available to provide advice and support to staff. The outpatient department had a link nurse who liaised with the dementia lead to make improvements in the department. There were large clocks placed in the waiting areas and there were plans to paint the toilet doors in specific colours.

Staff adapted the environment as far as possible when requested for a patient living with learning disabilities. VIP passports were used, which gave specific information about an individual’s needs.

Staff had access to interpreters, these would be booked at the same time as booking the patient’s appointment.

Clinics we visited had a range of patient information leaflets, some of these were available in different languages.
Access and flow

At our previous inspection, there were concerns with waiting backlogs and referral to treatment times. At this inspection, we found that although there was still a backlog of patients waiting for appointments this had improved and referral to treatment times had also improved, despite an increasing number of referrals.

At our last inspection, the backlog of patients waiting was 19,647, this had reduced to 17,516 in June 2018. There had been a reduction in the number of patient’s waiting more than 35 weeks from 449 in June 2017 to 193 in June 2018. There were no patients waiting over 52 weeks.

Some specialities, such as ophthalmology and trauma and orthopaedics, which had the biggest backlog, had decreased their backlog whilst for others, such as gastroenterology, neurology and rheumatology, it had increased. It was not clear what the reason for the increases were in some services, there was no evidence that increased referrals to the service had an impact on the backlog. Ophthalmology still had the highest backlog but this had reduced from 6942 at our last inspection to 5407 in April 2018. Data received following the inspection showed that this had reduced further still to 5272 by the 25 July 2018.

We saw a waiting list initiative spreadsheet, which had been produced so that extra clinics could be held. This indicated the speciality, how many consultants there would be, rooms needed and the proposed date and time of the clinic. This spreadsheet was then checked by the matron and managers who indicated whether a room and a nurse could be provided for the clinic to take place.

The outpatient efficiency dashboard showed a target of 95% for clinic slot utilisation, between January and March 2018 clinic slot utilisation was at 85.5%. For some services, clinic slot utilisation was affected due to staff availability.

The service had undertaken several initiatives to try to balance capacity and demand, including increasing internal capacity through some evening and weekend clinics, carrying out an in-depth review of ophthalmology services and increasing the use of alternative providers, for example dermatology patients may be triaged as being suitable to be seen by an independent provider.

The trust had worked closely with the local clinical commissioning group (CCG) to reduce waiting times and improve performance against cancer targets. Summit meetings were held which brought together secondary and primary care along with the CCG to look at the whole pathway.

We asked for evidence of clinical and recovery plans for high risk specialities. We were provided with an ophthalmology service improvement programme and an endoscopy surveillance trajectory briefing. These showed that endoscopy services had planned to clear their backlog by June 2018, but this had not been achieved and at the 22 June 2018 there were still 162 patients waiting. It was not clear from the ophthalmology improvement programme what the trajectory was for clearing the backlog.

At our last inspection, no specialities were above the England average for non-admitted referral to treatment times (RTT) or incomplete pathways RTT and there had been a downward trend in performance. At this inspection, although the trust performance had been worse than the England average overall, figures showed an increasing performance and three specialities were above the England average for non-admitted pathways and five specialities were above the England average for incomplete pathways.

In May 2017, the trust ranked 182 out of 189 nationally for their 18-week performance, in May 2018 this had improved to 130 out of 185.

Data provided by the trust showed that the number of non-admitted breaches, waiting more than 18 weeks had decreased from 3998 in June 2017 to 2459 in June 2018.
Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From May 2017 to March 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for March 2018 showed 83.9% of this group of patients were treated within 18 weeks versus the England average of 80.8% showing an increase in performance against the England average.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Three specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>91.0%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87.7%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>86.0%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>

15 specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>91.3%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>89.1%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Other</td>
<td>88.5%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>88.0%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>87.0%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>85.4%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>84.5%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.3%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>83.3%</td>
<td>89.6%</td>
</tr>
<tr>
<td>ENT</td>
<td>76.3%</td>
<td>87.2%</td>
</tr>
</tbody>
</table>
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance, and has not met the 92% target.

The trust performance has shown a steady increase since April 2017 but as of February 2018 remains below the England average.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, The Mid Yorkshire Hospitals NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Five specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>97.3%</td>
<td>96.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>96.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>92.2%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>89.5%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>84.6%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

12 specialities were below the England average for incomplete pathways RTT (percentage within 18 weeks)

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>88.6%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Other</td>
<td>87.7%</td>
<td>90.9%</td>
</tr>
<tr>
<td></td>
<td>This Trust</td>
<td>England Avg</td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>ENT</td>
<td>86.8%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>86.3%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>83.9%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.3%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>82.8%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>81.6%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>77.1%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>73.5%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>71.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>67.9%</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust had performed better than the operational standard for cancer waiting times. Although there had been a slight decline in performance for people waiting less than 62 days for urgent GP referral and they had not met the standard for quarter four of 2017/18, they were still in line with the England average. This was an improvement since the last inspection when the trust had performed worse than the operational standard.

When we spoke with staff about this they told us that they had seen an increased number of referrals linked to public health campaigns. They had recently recruited more staff and were holding weekly breach meetings, looking at those patients who had been waiting over 50 days to try and move forward. Extra clinics were held and root cause analysis done on every breach.

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

(Source: NHS England – Cancer Waits)
Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Did not attend rate

From February 2017 to January 2018,

- The ‘did not attend’ rate for Pontefract Hospital was lower than the England average.

The chart below shows the ‘did not attend’ rate over time.
Proportion of patients who did not attend appointment, The Mid Yorkshire Hospitals NHS Trust

![Proportion of patients who did not attend appointment](image)

(Source: Hospital Episode Statistics)

Patient feedback had included that they would like an appointment reminder. A texting pilot had been rolled out, where texts were sent to patients to remind them of their appointments.

A pilot was underway in plastic surgery for patient initiated follow up, where an appointment date and time would not be sent but a letter sent asking the patient to call to make an appointment that was convenient for them.

The patients we spoke with during our inspection told us they did not have long waits for their appointments. Any long waits would be indicated on a board in the waiting area. However, we did hear one patient’s family member complaining to staff that they had waited a long time and they were upset that someone else had been seen before them. Staff took the time to listen and explain the situation and the reason for the wait.

Learning from complaints and concerns

We saw information displayed informing patients how to make a complaint. Leaflets were available for patients which told them how to make a comment, complaint or express their appreciation. The leaflet contained contact details for the complainant to use to submit a complaint, an explanation of what would happen next, and of what to do if the patient remained dissatisfied following the investigation of their complaint.

Summary of complaints

From April 2017 to March 2018 there were 298 complaints about outpatients trustwide. The trust took an average of 29 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 30 days.

Complaints in relation to patient care accounted for 47% of all complaints received and were the largest theme in outpatients.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Although these complaints appear to relate to outpatients, most them were dealt with by the specialities and were not specific to the outpatient department.

The last formal complaint made specifically about the outpatient department was in March 2017.
Staff we spoke with told us that most complaints were informal and were resolved at department level.

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 115 compliments within outpatients.

 *(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

### Is the service well-led?

#### Leadership

The outpatient’s department was part of the division of surgery, access, booking and choice. Access booking and choice had a deputy director of operations, a patient services manager and a group manager.

Since our last inspection there had been a change in the leadership. A new lead had been appointed for the access, booking and choice directorate and a new outpatient matron had been appointed. The outpatient matron had been in post since September 2017. Prior to this, staff told us they were without a matron for around 18 months.

Staff at Pontefract hospital spoke positively about their leaders, they felt well supported by the matron. They told us that the executive team were visible and they received weekly emails from the chief executive.

#### Vision and strategy

We saw the outpatient mission statement and team philosophy on display in the main outpatient area.

The outpatient service had developed its strategy in line with the trust strategy.

Staff were aware of the trust vision and strategy.

#### Culture

Staff we spoke with were proud of their teamwork. They felt they all worked well together.

Staff spoke positively about the service and the trust. Morale was good.

Staff were passionate about their work and the service they provided to patients.

#### Governance

The division of surgery, access, booking and choice had a clinical governance manager.

There were governance structures in place which ensured that information was fed from operational level up to board level. The access, booking and choice directorate held governance meetings, these reported to the divisional governance meetings, which in turn reported to the quality committee and this reported to the board of directors. Any serious issues could be escalated through these meetings up to board level.
Governance meetings looked at incident reporting and any trends, new guidance and alerts and reviewed the risk register.

**Management of risk, issues and performance**

Risk registers were reviewed monthly in governance meetings. Risks of 12 or above were referred to the divisional governance meetings. Divisional risk registers were then reviewed at the quality committee meetings.

A risk register was in place for the access, booking and choice directorate.

An outpatient efficiency dashboard had been developed to help specialities view and manage their performance against four key outpatient improvement schemes and associated key performance indicators. This gave information on hospital generated outpatient appointment cancellations under six weeks, did not attend (DNA) rates by speciality, consecutive DNA’s and clinic slot utilisation by speciality.

Joint planned care meetings were held fortnightly with commissioners to monitor performance.

**Information management**

Electronic requesting software was used for electronic requests for follow up appointments.

Standard operating procedures and process flows were available to support outpatients staff.

The service used the data it had in weekly and monthly performance reports and dashboards, which helped determine priorities.

**Engagement**

Staff we spoke with told us they could access a lot of information online. Staff said they could email the chief executive and he would respond to concerns.

A stakeholder forum had been involved in the redesign of clinic letters.

There was a patient representative for the division on the trust patient experience group.

Friends and family test questionnaires were offered to patients for them to provide feedback on the services provided.

Patients and visitors could leave comments and these were highlighted around the departments as ‘you said, we did’. For example, patients had highlighted that the department was warm and uncomfortable, the service had therefore raised funds and purchased fans.

Staff told us that staff meetings were not held regularly due to time constraints. However, the matron produced a monthly newsletter which gave information on any updates, incidents and complaints.