Airedale NHS Foundation Trust

Airedale General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	
Medical care (including older people's care)	
Surgery	
Critical care	**Requires improvement**
Maternity and gynaecology	
Services for children and young people	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused follow-up inspection between 28 and 30 March 2017 to confirm whether Airedale NHS Foundation Trust had made improvements to its services since our last comprehensive inspection in March 2016. We also undertook an unannounced inspection on 12 April 2017.

Focussed inspections do not look across a whole service; they focus on the areas defined by information that triggers the need for an inspection. Therefore, we did not inspect all the five key questions of safe, effective, caring, responsive and well led for each core service. We inspected core services which were rated requires improvement or where we had identified areas of concerns. We included the urgent and emergency services due to some concerns about safety in the department. We had received reports of a number of serious incidents related to missed diagnosis, therefore inspected the service to seek assurance that safety concerns were being appropriately addressed.

When we last undertook a comprehensive inspection of the trust in March 2016, we rated the trust as requires improvement. We rated safe and well-led as requires improvement. We rated effective, responsive and caring as good.

There were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing, good governance and safe care and treatment. The trust sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation.

The service was also inspected in September 2016 where there was a focus on critical care and medical care. The service was not re-rated during this unannounced inspection. During this inspection, we found the service had made some improvements.

At this inspection in March 2017, we checked whether the actions following the comprehensive inspection in March 2016 had been completed. We inspected the services at the Airedale General Hospital. We did not inspect community services provided by the trust as these were rated as good at the previous inspection.

We rated Airedale NHS Foundation Trust as requires improvement overall.

At this inspection we found:

- The trust had made progress taken action to address the issues identified at previous inspections, particularly in critical care. However, there remained areas that required further improvement and the trust was often reactive, rather than proactive in identifying areas for development.
- In particular, we found the governance arrangements required further strengthening. There had been changes made to the governance structure since our last inspection, but the reporting structure appeared complex and we found this was not clearly understood within the organisation. We were not assured from some of the recently reported incidents, including safeguarding incidents, that the systems and processes were fully effective.
- There was no evidence of recent review of the critical care risk register in accordance with trust processes. Risk assessments had not been reviewed since 2013. The ward improvement plan had not been updated since September 2016 and did not include recommendations from peer and external reviews.
- Some systems and processes required development to be fully effective. For example, the procedure for opening and closing extra capacity beds was not always followed and the systems for identifying and reporting mixed sex accommodation breaches on critical care were not effective.
- There had been investment and improvements made to nurse staffing and the trust were actively recruiting. However, the actual number of staff on duty were often lower than the planned numbers especially on some wards in surgery and medicine. There was also a shortage of specially trained children's nurses within ED.

Summary of findings

- Medicines management had improved since our previous inspection; however we identified examples of outstanding actions that had not been completed or interventions that had not been followed up following medicines reconciliation.
- There was inconsistency in the application of systems, processes and standard operating procedures, including the WHO five steps to safer surgery, to keep people safe, particularly within theatres.
- The environment in the Dales Unit, Haematology Oncology Day Unit and the cardiac catheter lab required addressing to ensure they met patient need and national guidance.
- Further development of the work around Workforce Race and Equality Standards (WRES) was needed. The trust recognised this.

However:

- Staff reported an improvement in the organisational culture since our previous inspection. There was evidence of a positive incident reporting culture.
- Improvements had been made to the safety and communication issues identified during our previous inspection for patients being monitored by telemetry (remote cardiac monitoring).
- We observed adherence to infection prevention and control guidance in most areas. Some areas for improvement were identified in surgery and maternity areas. Between April 2016 and February 2017, there had been reported 13 cases of C. difficile of which two were deemed avoidable. The trust reported three cases of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia in 2016/17, with no reported cases since June 2016.
- Systems were in place and we saw evidence of implementation of the duty of candour requirements.
- There continued to be a strong commitment to public engagement and we found creative initiatives to develop this further.
- The hospital standardised mortality ratio (HSMR) and the summary hospital-level mortality indicator (SHMI) for the trust were within the expected range when compared to the England average.

We saw several areas of outstanding practice including:

- The Frailty Elderly Pathway Team demonstrated a proactive approach to deal with vulnerable patients to ensure they got the right care as early as possible following hospital arrival. The team had built relationships across the internal multidisciplinary team, with social care colleagues and external care providers. The team have audited their performance and reported successes in admission avoidance, reduced length of stay, less intra-hospital moves, reduction in readmission rates, cost savings and improved patient experience. The team had been nominated for a national award.
- Patients on the early pregnancy assessment unit (EPAU) and gynaecology acute treatment unit (GATU) were asked to provide a password, which was used to maintain confidentiality and safety when calling the unit for test results.

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

Importantly, the trust must:

Trust-wide

- Ensure governance systems and processes are fully effective to ensure comprehensive learning from incidents.
- Review medicines reconciliation systems and processes to ensure actions from medicines reconciliation are acted upon in a timely manner.

Urgent and emergency care services

- Ensure that the relevant clinical pathways for children, including for sepsis, are in place.

Medical care services

Summary of findings

- Ensure the current capacity and demand issues faced by the Haematology Oncology Day Unit are reviewed and ensure the clinical environment where treatment is provided is fit for purpose in delivering patient care and treatment.
- Ensure safe nurse staffing levels and safe nurse staffing skill mix is maintained across all clinical areas at all times.
- Ensure the 'bleep rota' used to support nurse staffing escalation processes is revisited and ensure all escalation processes are effective in managing nurse staffing issues.
- Ensure all staff follow the standard operating procedure covering the opening and closing of extra capacity beds/ wards.
- Ensure all patients received onto the cardiac catheter lab are handed over to a member of staff immediately on arrival and are provided with a mechanism to contact staff in the event of a care need or emergency.

Surgery services

- Ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- Ensure that staff complete their mandatory training including safeguarding training.
- Ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.
- Ensure that the environment of the Dales suite is in line with national guidelines and recommendations.
- Ensure that patient records are stored securely.
- Ensure there is a robust, proactive approach to risk assessment and risk management which includes regular review.

Critical care

- Continue to implement the follow up clinic and rehabilitation after critical illness in line with Guidelines for the Provision of Intensive Care Services 2015 and NICE CG83 Rehabilitation after critical illness.
- Review the process of identifying, recording and reporting mixed sex accommodation occurrences and breaches on ward 16.
- Introduce a robust, proactive approach to risk assessment and risk management which includes regular review.

In addition the trust should:

Urgent and emergency services

- Ensure that nursing staff receive APLS training to ensure that the department is meeting the intercollegiate standards.
- Continue to recruit nurses of all disciplines, but particularly registered children's nurses to ensure that the department meets the Royal College of Nursing guidelines relating to 24 hour cover by a registered children's nurse in the department.
- Continue to ensure that all non-children's nurses attend the APES course to ensure that they have the skills to treat children in emergency situations appropriately.
- Ensure that the department has the appropriate nursing skill mix and ensure that all applicable nurses have undergone triage training.
- Ensure that there is assurance in place that the drugs room temperature does not exceed 25 degrees.

Medical care services

- Ensure learning from submitted incidents is relayed to the incident reporter, relevant staff in the local clinical area and consider initiatives to share lessons learnt to the division and wider trust personnel.
- Ensure patient risks are reassessed and documented in line with local policy and best practice guidelines.
- Consider reviewing the number of incident reporting categories used to promote better data capture and incident analysis into themes and trends.
- Ensure all patients self-medicating on divisional wards are fully assessed as safe to do so in line with local policy.

Summary of findings

- Consider a review of the divisional risk register, in particular to revisit the relevance of some historic risks listed and to ensure all current risks are rated according to actual impact on the division and the organisation.
- Consider evaluating some of the staff engagement initiatives to ensure the aims and objectives are effective and are meeting the divisional and trust agenda.
- Ensure clinical waste in the cardiac catheter lab is appropriately stored in a safe area whilst awaiting collection and onward disposal.

Surgery

- Monitor and improve the attendance at governance meetings.
- Ensure all patients self-medicating on the surgical day unit are fully assessed as safe to do so in line with local policy.

Critical care

- Introduce a process to review and share learning from critical care morbidity and mortality.
- Introduce a strategy to obtain and act on patient and public feedback.
- Ensure that staff understand the deprivation of liberty safeguards (DoLs) in order to plan and deliver effective treatment and care.
- Review the capacity and demand on the service and develop a business plan in line with the trust's strategy.
- Continue to deliver care in line with and address the areas where they do not meet the Guidelines for the Provision of Intensive Care Services (2015), for example, nursing staff with a postgraduate qualification and medical staffing.
- Continue to develop the use of competency frameworks and clinical education.

Maternity and gynaecology

- Ensure robust processes are in place to inform staff defective equipment has been reported.
- Ensure community midwives document the named midwife on the antenatal record.
- Work to improve the accuracy of mandatory training data.
- Work to improve the attendance by medical staff at mandatory training.
- Review the leadership structure on early pregnancy unit (EPAU) and gynaecology acute treatment unit (GATU), to ensure there is appropriate accountability and support.

Children and young people's services

- Ensure all equipment is inspected within the required time-frame and ensure there is robust service management oversight of the equipment maintenance assurance log.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		• Although the department had experienced some serious incidents, these had been thoroughly investigated and action taken to implement changes and reduce the risk of further similar incidents. Audits were carried out to provide assurance that changes were being implemented. • Patients received care in a clean and well-appointed department with sufficient equipment to support their health needs. • There were effective processes in place to protect children and vulnerable adults from abuse. • The department was led by an effective leadership team. The department involved staff and patients in discussions about the future development of the service and had a vision and strategy to ensure that patient needs were met in the future. However: • Although the department was, regularly and actively recruiting nursing staff there was a shortage of nursing staff, particularly registered children's nurses and nurses who were trained to advanced paediatric life support standard. Not all appropriate staff had undergone additional training provided by the department to enable them to treat children in an emergency. • There were some consultant and middle grade medical staff vacancies that were having an impact on rota cover and not sustainable in the long term. • The department did not have all of the relevant pathways in place to assess and manage the risks for paediatric patients.
Medical care (including older people's care)		• Learning from incidents was not fully embedded and there were missed opportunities to share lessons to improve patient safety.

Summary of findings

- Whilst there has been a reduction in patient harms, there continued to be a number of reported incidents classified as patient accidents, in particular, relating to falls and pressure ulcers.
- The clinical environment in the HODU was not fit to meet current capacity and demand issues resulting in care being delivered in overcrowded facilities.
- The clean and dirty utility facilities in the cardiac catheter lab were insufficient for the number of procedures performed. This led to waste being stored in any inappropriate area.
- The standard operating procedure for the opening and closing of extra capacity beds/ wards was not always followed.
- Some medications requiring refrigeration were stored in a fridge, on a ward which was not constantly staffed and sometimes closed, without the required daily safety checks completed to ensure medication integrity.
- Patients waiting in the cardiac catheter lab had no means to alert staff in the event of a care need or emergency.
- There were periods of understaffing and inappropriate skill mix on some wards. The 'bleep holder' initiative to support escalation procedures in nurse staffing was not fully effective.
- The governance framework had undergone recent review; however the new processes were not fully embedded across the division.
- The divisional risk register provided risks back to 2012. The top three rated risks within the risk register did not mirror those reported by the leadership team. There were no group risks rated as 16 or above (high to very high category).
- Staff morale and satisfaction was mixed.

However,

- Staff were confident in reporting incidents and understood incident reporting procedures.

Summary of findings

- There had been a proactive effort to target key themes relating to patient harms, which had brought about some improvements in harm-free care. Safety thermometer data was displayed consistently on wards in a user friendly format.
- All equipment checks met local policy standards, national guidelines and/or manufacturer recommendations.
- Staff considered there had been a positive shift in the organisational culture in the past 12 months. Staff considered the leadership team and line managers to be more visible, approachable and receptive to concerns.

Surgery

- The Dales suite was not compliant with guidance from the Department of Health for specialised ventilation for healthcare premises.
- In some clinical areas, we observed poor compliance with the trusts infection prevention and control policy and there was an inconsistent approach to the storage of single use equipment and the decontamination of laryngoscopes in theatre.
- There was inconsistency in the application of systems, processes and standard operating procedures, including the WHO five steps to safer surgery, to keep people safe, particularly within theatres.
- Records were not always stored securely and there was a risk that patient's confidential information could be accessed.
- There were occasions when actual nurse staffing levels were not in line with planned nurse staffing levels.
- Risks that threatened the delivery of safe and effective care were not always identified promptly and adequate action taken to manage them.

However,

- Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system. We saw evidence of lessons learnt and changes in practice following incidents.

Summary of findings

- Patient's observations were correctly recorded and patients who were at risk of deteriorating were escalated in a timely manner.
- There were processes in place to ensure that medication was stored securely. Medications that required refrigeration were stored appropriately in fridges.
- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence). Staff were clear about their role in reporting and escalating a safeguarding concern.
- The service had clear governance structure and a clear responsibility and accountability framework had been established. Staff were clear about their roles and understood their level of accountability.
- All staff spoke positively about the visibility of the senior management team and felt staff engagement and the culture within the organisation had improved.
- Each ward had an improvement plan which was reviewed regularly by the ward leader, matron and director of nursing. Staff felt these helped drive improvement.

Critical care

Requires improvement

- Although there had been improvements, some of the issues raised at the 2016 inspection remained a concern. For example, the lack of a long term strategy, limited evidence available to show that the service had improved the arrangements for the management of risk, the unit still had some delayed discharge rates that were worse than similar units and at the time of the inspection there was no follow up or support to critical care patients following discharge from hospital.
- The leadership team appeared to have a reactive approach to risk assessment and risk management. Some of the unit's risk assessments had been written between 2009 and 2013. There was no evidence that senior staff had reviewed the risk assessments since these dates.

Summary of findings

- The arrangements for coronary care beds for level one and zero dependency patients within the same location as critical care patients of level two and three dependency was not in line with the national service specification. The trust had approved a business case for relocation of these beds; however, the senior management team were unable to confirm the date for the implementation of this.
- Staff knew the future of the unit was for coronary care to move to another ward, but they were unable to tell us of a longer term vision or how critical care linked in to the trust's strategy.
- The rehabilitation after critical illness service was limited. At the time of the inspection there was no follow up or support to patients following discharge from hospital. This was not in line with Guidelines for the Provision of Intensive Care Standards 2015 (GPICS) or the National Institute of Health and Care Excellence (NICE) CG83 rehabilitation after critical illness.
- The service did not have access to patient and relative support groups.
- The service had not undertaken patient or relative surveys or any public engagement in service planning.
- Staff we spoke with had a limited understanding of the deprivation of liberty safeguards (DoLs).
- The service was still working towards some of the GPICS standards. For example, the service did not hold critical care specific morbidity and mortality meetings and out of hours medical staffing was not in line with GPICS standards.

However,

- The service had taken action on many of the issues that related to safe and effective patient care that were raised in the 2016 inspection. For example, nurse staffing levels were now in line with GPICS and the consultant work pattern had changed to provide continuity of care. The unit now had a dedicated clinical educator and the service held records of staff's 'self-assessment competency' of equipment and records of who had received training for specialist equipment.

Summary of findings

- There had been a significant change to the leadership team since our 2016 inspections. All staff were positive about the team and morale on the unit had improved significantly. Staff engagement had also improved.
- Systems and processes in incident reporting, infection control, medicines management, patient records and the monitoring, assessing and responding to deteriorating patients were reliable and appropriate.
- Staff were supported to maintain and develop their professional skills. Mandatory training and safeguarding training rates were better than the trust target.
- Care and treatment was planned and delivered in line with current evidence based guidance and patient outcomes were in line with similar units.
- We observed patient centred multidisciplinary team working. Staff took account of, and were able to meet people's individual needs. All of the feedback from patients and relatives was positive about the way staff treated them.

Maternity and gynaecology

- Processes had been put in place to ensure staff had checked emergency equipment. Staff also knew how to check equipment and what to do if there were any concerns.
- Staff were aware of how to report incidents and were confident they would be investigated and findings shared throughout the service. We found a no blame culture and there were good working relationships between the medical, nursing and midwifery staff.
- There were effective infection prevention and control practices in maternity; when we highlighted some areas of concern these were immediately rectified.
- There were effective processes in place to ensure that risks were managed appropriately this included safeguarding and risk assessments. We found documentation was of a good standard, with monthly audits, which helped to maintain standards.

Summary of findings

- The service had enough staff to care for the number of patients and their level of need. Staff knew and put into practice the service's values and they knew and had contact with managers at all levels, including the most senior.
- The senior management team were visible within the service and had an open door policy. There were plans in place to move the service forward to support the changing needs of their commissioners and the local community. During our inspection we observed good cross directorate working between the senior management team and the surgical directorate.

However:

- There was a discrepancy between the training data provided by the trust and the directorate data. Attendance by medical staff was significantly below the targets set by the trust.
- The early pregnancy unit (EPAU) and gynaecology acute treatment unit (GATU) was a very specialist unit; however, we were concerned with the management of this unit as it was accountable to both the maternity and gynaecology service the surgical directorate.

Services for children and young people

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Staff had the skills they needed to carry out their role effectively and in line with best practice. Managers were visible and there was a real strength, passion, and resilience across medical and nursing teams to deliver high quality care to children, young people, and their families.
- Since the previous CQC inspection, managers had taken appropriate action to mitigate and manage risk to children and young people by improving medical staffing and by implementing short-term contingency plans on the children's ward.
- Staff told us they were proud to work for the trust and promoted a patient-centred culture. Children, young people and parents felt medical and nursing staff communicated with them effectively, and made them feel felt safe.

Summary of findings

- Staff protected children and young people from avoidable harm and abuse, and they followed appropriate processes and procedures to keep them safe. The named nurse for safeguarding children was in the process of establishing a new safeguarding supervision model, to ensure staff shared best practice and lessons learnt from serious incidents and serious case reviews involving children and young people.

Airedale General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people.

Detailed findings

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Background to Airedale General Hospital

Airedale NHS Foundation Trust provides acute and community services to a population of over 200,000. The trust primarily serves a population people from a widespread area covering 700 square miles within Yorkshire and Lancashire, including parts of the Yorkshire Dales and the National Park in North Yorkshire, reaching areas of North Bradford and Guiseley in West Yorkshire and extending into Colne and Pendle in the East of Lancashire.

The main hospital site is Airedale General Hospital, which provides a range of acute services. Community services are provided across the north of the region from sites including Coronation Hospital in Ilkley and Skipton Hospital.

There were approximately 379 beds at this trust including 295 general and acute care, 27 maternity and ten critical care beds.

The catchment area of Airedale NHS Foundation Trust includes people in Craven and Pendle district

Councils as well as from Bradford and Leeds unitary authorities. Bradford and Pendle both performed in the lowest 25% in inequality indicators for deprivation, whilst Craven was in the best 25%.

The trust's main Clinical Commissioning Group is Airedale, Wharfedale and Craven Clinical Commissioning Group.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, retired Medical Director

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultants, junior doctors, director of nursing, safeguarding lead, paediatric nurses, midwives and A&E nurses.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

The inspection team inspected the following core services at Airedale General Hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS England and the local Health watch.

Focus groups were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward area. We observed how people were cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

Facts and data about Airedale General Hospital

- From January 2016 to December 2016 the trust had 57, 656 A&E attendances, 235,967 outpatient appointments, 53,370 inpatient admissions, 2,112 births, and 683 deaths.
- The catchment area of the trust covers people in Bradford, Craven and Pendle. The health of the people across these locations varied compared with the England average. In Bradford and Pendle, deprivation is lower than average and in Craven it is higher than the England average. The number of children living in low income families is worse than the England average for Bradford and Pendle while Craven is better than the England average. Life expectancy for both men and women is worse than the England average for Bradford and Pendle, while Craven is better for both men and women.
- From January 2016 to January 2017, the trust had one never event (in surgery) and 19 serious incidents. In the same reporting period the trust reported 5,829 incidents with 98% categorised as low or no harm.
- Mortality data for the trust showed that from October 2015 to September 2016, the hospital standardised mortality ratio (HSMR) was within the expected range of 91.50 compared to an England average of 100. The summary hospital-level mortality indicator (SHMI) was within the expected range of 0.93 compared to an England average of 1.0.
- In the NHS Staff Survey (2016), the trust performed better than other trusts in 11 questions, about the same as other trusts in 10 questions and worse than other trusts in 11 questions. Overall staff engagement ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.81 was average when compared with trusts of a similar type.
- The trust had a deficit of £998k for 2015/16. This was £208k better than anticipated and when the total income from activity was taken into consideration, the Trust had a cash balance of £11.6 million at the close of the financial year.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	N/A	N/A	N/A	Good	N/A
Medical care	Requires improvement	N/A	N/A	N/A	Requires improvement	N/A
Surgery	Requires improvement	N/A	N/A	N/A	Requires improvement	N/A
Critical care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	N/A	N/A	N/A	Good	N/A
Services for children and young people	Good	N/A	N/A	N/A	Good	N/A
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

Notes

Urgent and emergency services

Safe	Requires improvement
Well-led	Good
Overall	

Information about the service

The emergency department (also known as accident and emergency, A&E or ED) is at the Airedale Hospital in Keighley. It is a trauma centre, which means that it can treat patients with a range of illnesses and injuries, including those who have been involved in accidents and incidents. Patients involved in more serious accident and incidents are taken to the closest major trauma centre. Patients can arrive on foot or by road in an ambulance. Within the department, there are three main areas where patients are treated. The minors department can treat patients with minor injuries such as simple fractures; the majors department treats patients with more serious illnesses or injuries and has 17 cubicles and the resuscitation area with four cubicles treats patients who are seriously ill or who need observation and close monitoring. One of these bays is suitable for children and one suitable for trauma patients.

A wide range of experienced consultants, middle grade and junior doctors, emergency nurse practitioners, nurses and healthcare assistants staff the department, seven days a week, 24 hours a day.

During our inspection, we visited the main A&E department.

We spoke with staff including doctors, nursing assistants and nurses of all grades. We looked at the records of 14 patients and reviewed information about the service provided by external stakeholders and the trust.

Last year the emergency department saw 57,032 patients. There were 13,194 children seen. This equates to 23% of patients in the department being under the age of 18.

We last inspected the department in March 2016. At that inspection, we rated the department as 'Good' for 'safe', 'effective', 'caring', 'responsive,' and 'well led'.

This was a responsive inspection carried out because we had some concerns about safety in the department. We received reports of a number of serious incidents related to missed diagnosis. At this inspection, we inspected two key questions, 'Safe' and 'Well led', to seek assurance that safety concerns were being appropriately addressed.

Urgent and emergency services

Summary of findings

At this inspection we rated safe as requires improvement and well-led as good:

- Although the department had experienced some serious incidents, these had been thoroughly investigated and action taken to implement changes and reduce the risk of further similar incidents. Staff were engaged in the process and informed of any changes to practice. Audits were carried out to provide assurance that changes were being implemented.
- Patients received care in a clean and well-appointed department with sufficient equipment to support their health needs from staff that followed infection control procedures and had undergone training to make sure they were competent to use equipment.
- There were effective processes in place to protect children and vulnerable adults from abuse and liaise with partner agencies when concerns were raised.
- Quality assurance and governance processes made sure that the department was treating patients in line with national guidance and escalating the care of patients appropriately if their health deteriorated. Risks to patients and within the department were managed and action taken to reduce risks wherever possible.
- The department involved staff and patients in discussions about the future development of the service and had a vision and strategy to ensure that patient needs were met in the future.
- The department was led by an effective leadership team.

However:

- Although the department was, regularly and actively recruiting nursing staff there was a shortage of nursing staff, particularly registered children's nurses and nurses who were trained to advanced paediatric life support standard. Not all appropriate staff had undergone additional training provided by the department to enable them to treat children in an emergency.
- There were some consultant and middle grade medical staff vacancies that were having an impact on rota cover and not sustainable in the long term.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- The department did not have sufficient registered children's nurses working in the department and the number of trained Advance Paediatric Life Support (APLS) trained nurses. Although the department had given some registered adult nurse's additional training, it was not able to meet the Royal College of Nursing (RCN) standard of having a paediatric nurse on duty 24 hours per day.
- The department did not always have the skill mix of nurses on duty required to fulfil the requirements of the department, such as more than one nurse able to triage patients.
- Nursing staff were being loaned to other wards and departments, which on occasion led to staff or skill mix shortages.
- The department had some medical staff vacancies that were having an impact on medical cover and rotas. The trust was continually looking to recruit to these posts and using locum staff cover.
- Although staff reported incidents, these were not always reported in a timely manner.
- The department did not have all of the relevant pathways in place to assess and manage the risks for paediatric patients.

However:

- Serious incidents were investigated thoroughly and findings reported to staff with actions and changes in practice where applicable.
- The department and staff followed infection prevention and control measures closely. The department was clean and tidy throughout and there was sufficient space and equipment to meet patients' needs.
- Records were of an acceptable standard and contained the necessary information about patients.
- Safeguarding processes and procedures were in place and vulnerable patients (children and adults) concerns had oversight from a paediatric liaison nurse.
- Patients were monitored for deterioration and action taken if patients became unwell.

- Medication was stored securely and dispensed to patients safely.

Incidents

- There were no never events reported by the department. 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.
- Between January 2016 and December 2016, 287 NRLS incidents were reported in the department. Of these, the outcomes were; 202 no harm, 76 low harm, two moderate harm, one severe harm and three deaths The most common categories of incident were treatment/ procedure 50, implementation of care 45 and infrastructure 42. Staff had reported 33 incidents relating to low staffing or poor skill mix including four where there were limited numbers of triage trained staff on shift and eight where staff were asked to work on other wards leaving the department under staffed.
- When we spoke with staff about reporting incidents, all staff told us that they reported incidents and had access to the system to do so. Staff told us that they received feedback from incidents at department meetings. Managers showed us the work they had undertaken because of recent serious incidents including meeting with staff involved.
- Of the 287 incidents reported, we saw that staff did not always report incidents in a timely manner. For example, only 61 incidents were reported within 30 days, 88 were reported within 60 days, 75 within 90 days and 63 over 90 days. The department reported 782 incidents from February 2016 to January 2017. Of these, 337 resulted in no harm, 429 in low harm, two moderate harm and two catastrophic harm or death.
- We spoke with staff about their responsibilities around duty of candour. Most staff understood what the phrase meant and were familiar with the phrase, 'being open and honest'. Senior staff in the department took responsibility for the formal duty of candour process. They were able to describe it and give examples of when they had used the process. We saw examples of duty of candour being reported along with information about incidents the trust sent to us.
- Mortality and Morbidity meetings took place across the trust and staff from the department routinely attended and reported any findings or lessons learned at departmental meetings. Minutes were also emailed to staff. We saw evidence of meeting minutes

Cleanliness, infection control and hygiene

- The department was clean and tidy. Domestic staff used 'I'm clean' stickers on equipment to show when they had last cleaned the equipment.
- The department housekeeper cleaned beds and mattresses thoroughly every week and staff cleaned any superficial marks after each patient used beds and trolleys. The housekeeper was also available to carry out further cleaning as required during the week. We looked at five mattresses around the department and found them to be clean with their protective coverings intact.
- The waiting room and cubicle areas were in good order and patient toilet facilities were clean. Staff regularly cleaned the toys in the children's waiting room.
- Staff were able to access a ready supply of personal protective equipment such as aprons and gloves and we saw these being disposed of appropriately throughout the inspection.
- There were full hand gel dispensers around the department, in supervised areas to prevent patients from ingesting the contents.
- The hospital sent us evidence that the department had regular formal environment and cleanliness checks at least every month. The department consistently scored over 95% in these checks and where problems were identified, the report clearly showed how staff had taken action to resolve the issue.
- The department had some cubicles with fixed doors that they could use to isolate patients. This meant that other patients were protected from the risk of contracting contagious conditions such as diarrhoea and vomiting. Staff were able to effectively manage and prevent the spread of infection.
- The trust delivered mandatory infection prevention training. The trust target was 80%. Nursing staff training was at 78% with medical staff training at 85%.
- The trust routinely monitored staff hand hygiene procedures. We looked at the audit data for February 2016 to February 2017. The department had failed to submit data for two months however, had scored 100% in the remaining 11 months. The department was

compliant with hand hygiene techniques. Additionally, on inspection we saw that all staff adhered to hand hygiene procedure and were arms bare below the elbows.
- There had been no reports of MRSA (Methicillin-resistant Staphylococcus aureus) or C.difficile (Clostridium difficile) in the department.

Environment and equipment

- The department was situated in a new purpose built area. It was light and spacious with natural light. There were four enclosed cubicles, eight curtained cubicles and four resuscitation rooms one of which was flexible to use for both adults and children. The department also had a comfortable observation area for patients who needed to remain in the department but who did not need to occupy a bed.
- Consulting and treatment cubicles were large and contained the necessary patient equipment. Cubicles had solid walls and curtain doors. Despite this, privacy and dignity were maintained and patients were able to have confidential conversations. Staff told us that in times of extreme demand, rather than place patients in corridors, the cubicles were large enough to house two patients on trolleys with a screen to separate them. This had only happened once but demonstrated the size and flexibility of the cubicles.
- The waiting area used by patients was airy and had natural light. Reception staff could clearly see the waiting area. On the days we visited, we did not see any problems with overcrowding or lack of seats.
- There was a separate waiting area for children and young people. It was appropriately decorated and contained toys and entertainment suitable for young people. The door to the waiting room had the capability to be locked at all times however staff told us that it would only ever be locked if the department was on lockdown due to security concerns. The department also had suitably decorated cubicles for children and young people to receive treatment.
- We looked at the medical equipment the department used. We found two pieces of medical equipment that had not been serviced within the last 12 months. We pointed these out to staff and they were removed from service and serviced within the hour. All of the other equipment we looked at, in cubicles and in the four resuscitation rooms had been serviced regularly.
- Equipment was serviced and maintained in line with manufacturer's guidelines, as there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated.
- We saw that there were sufficient supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available quickly.
- We looked at the resuscitation trolleys in the department. Staff were responsible for daily and weekly checks of drugs and equipment on the trolleys. The logs staff showed us provided evidence that regular checks were carried out. All trolleys were sealed securely with tamper proof seals to ensure that no contents could be removed without staff noticing. The trolley in the paediatric resuscitation bay had specific paediatric equipment however there was also a trolley stocked with adult sized equipment in the bay.

Medicines

- The department used an electronic medication system to store drugs. There were three storage units within the department. One unit contained take home medication that was prescribed to patients and that had to be paid for by the patient. This included antibiotics and pain relief as well as other prescription medication. There was a storage unit in the locked drugs room. Staff needed to be registered on the system and had to use a finger print or password to access medication. This unit also contained controlled drugs.
- Controlled drugs were stored in line with national and trust policy and stock checks were routinely completed.
- The drugs room held a locked fridge. The housekeeper checked the fridge temperatures daily and reported any inconsistencies to the shift leader who was responsible for taking action and informing pharmacy staff.
- The drugs room had no temperature checks and there was no thermometer in the room. We expressed some concerns about the temperature of the room to the shift leader. This was because many medications are recommended to be stored under 25 degrees and the room was very warm. There was no assurance in place that the drugs room temperature was below 25 degrees.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. Staff had signed to say that they understood them and were working within their

guidance. All PGDs were within date and reviewed regularly. The department manager held a comprehensive list of which members of staff had attended training to be able to use PGDs.

Records

- The department used paper records at the time of the inspection however, was planning to move to an electronic records system in the future.
- We looked at the records of eight child and six adult patients. We found that the records showed a clear medical history, action plan and treatment plan. Of the eight children's records, only one had a pain score recorded despite four patients attending with either head or limb injuries. One patient without a pain score received pain relief.
- Staff used NEWS (National Early Warning Score) or PAWS (Paediatric Advance Warning Score) to monitor patients. Staff had completed these scores for each patient who presented as unwell. Staff had completed the PAWS/ NEWS score appropriately in the records we looked at. A current PAWS audit was underway with initial results showing some areas for improvement however at the time of writing the report, full analysis had not been completed.
- Staff were undertaking record keeping audits to ensure that all relevant information was captured. Discrepancies were presented to colleagues.
- The records we looked at showed that nursing care, such as supporting patients to eat, or take comfort breaks had taken place. The department used intentional rounding and this was recorded in records.
- Records were stored securely and accessible only to appropriate people.
- Professional and scientific staff were meeting the trust target of 80% for information governance training however, additional clinical services (47%), medical (77%) and nursing (62%) were not.
- We looked at the standard of other records kept in the department such as cleaning logs, medication fridge checks, and resuscitation trolley checks. We found that these were consistently completed.

Safeguarding

- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated theoretical knowledge.
- Safeguarding children referrals were discussed at a daily meeting and all child cases were reviewed to ensure that none had been missed by staff.
- The department had a paediatric liaison nurse who was responsible for overseeing safeguarding processes within the department, making sure that community based healthcare staff were aware of any vulnerable children attending the department and supporting staff who raised safeguarding concerns to make sure that the correct procedures were followed. We saw evidence that referrals for vulnerable adults and children were regularly made and information sent to health visitors about children who attended the department.
- Safeguarding training included specific training about safeguarding topics such as child sexual exploitation (CSE), people trafficking and female genital mutilation (FGM).
- The IT system used by the department routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about patients' welfare or where there was social services interaction, the system also displayed an alert to staff that gave specific details about any risks to the patient or to staff.
- When we looked through patient records, we saw that staff had escalated any safeguarding concerns correctly.
- The department standard of 80% of staff attending appropriate safeguarding training was not always being met. For example, 54% of medical staff had attended safeguarding level 3 training although 100% had attended safeguarding adults training. Nursing staff were meeting the 80% standard for safeguarding adults, children level 2 and children level 3 training. Other staff within the department were also meeting the 80% standard for appropriate safeguarding training.
- One of the consultants within the department had a particular interest in safeguarding children and was in the process of carrying out a retrospective audit of patient records to make sure that appropriate action

had been taken when concerns had been raised. Initial results were showing positive results. They were also carrying out work to look at the volume and type of safeguarding concerns that were seen within the department.

Mandatory training

- Staff told us they could access some mandatory training via the intranet. They reported few problems accessing e-learning other than the occasional shortage of free time or computers.
- None of the staff groups were fully meeting the target of 80% for all mandatory training. For example, medical staff were failing to meet the 80% standard in basic life support, conflict resolution, equality and diversity, information governance and manual handling. Nursing staff were not meeting the standard in blood transfusion, conflict resolution, equality and diversity, infection prevention, information governance and staff and patient safety.
- Managers monitored staff training closely and kept a comprehensive log of when staff were due training. Managers were able to show us when all staff were booked in to have training updates. However, at the time of inspection, none of the staff groups were fully up to date with all of their mandatory training.
- There were no nursing staff in the department who had completed advanced paediatric life support (APLS) training.

Assessing and responding to patient risk

- Between 1st February 2016 and 31st January 2017, the hospital had 16 incidents of patients waiting over 60 minutes to be handed over from ambulance staff to hospital staff. The most occurrences happened in January 2017 when five patients waited more than 120 minutes and a further two patients waited more than 60 minutes. In percentage terms, this equated to less than 0.2% of patients.
- Over the same time period, the trust reported 145 delays of handovers of more than 30 minutes from ambulance staff to hospital staff. This meant that patients were waiting on ambulance trolleys or in wheelchairs under the care of ambulance staff for more than 30 minutes. In percentage terms, this equated to less than 2% of patients.
- The percentage of ambulance handovers taking between 15 and 30 minutes was 14%.
- The average handover time at Airedale General Hospital was under 10 minutes. Over 85% of patients consistently had handover within 15 minutes. Airedale was one of the top three performing hospitals for handover times in the Yorkshire Ambulance region.
- The department used the Manchester Triage system to assess how urgently patients needed to be seen. Staff who carried out triage were experienced ED practitioners who had undergone specific triage training before being placed in a triage role.
- Patients were triaged on attending the department and staff based their decisions about whether the patient should be treated in the minors or majors area.
- The department had a sepsis screening tool and pathway for adults but had not fully developed the paediatric sepsis pathway at the time of inspection. We contacted the trust in mid-June to make sure that the paediatric pathway had been finalised and implemented. The trust told us that they were still making a decision about which of three pathways to adopt. This was 10 weeks after our initial inspection.
- The department had trialled the use of the rapid assessment and treatment triage model; however found that it was not a model that worked well in the department. Triage was carried out using the traditional model because the department staff thought that this worked better for patients.
- We tracked the journeys of 13 patients who self-presented at the department. Of these patients, six were seen within 15 minutes, five waited more than 15 minutes and two patients had no times written in their records. One patient waited more than an hour for an initial assessment.
- Patients with allergies wore a red wristband to ensure that they were easily identifiable.
- Staff recorded known patient allergies in patient records. All of the 14 records we looked at had documented whether a patient had allergies or not.
- Patients had their observations taken regularly and the department used NEWS or PAWS to assist in identifying patients whose condition was deteriorating. Staff were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. There was evidence in seven sets of records that observations had been carried out. Observations were not applicable for the remaining patients because they were in the department for a short time.

- There was emergency medical equipment in the department and staff were experienced at dealing with very sick patients. There were senior staff on hand to support less experienced staff 24 hours a day.

Nursing staffing

- The department had a shortage of specially trained children's nurses. There were only two qualified children's nurses employed by the department. The trust was finding it difficult to recruit qualified children's nurses and was not meeting the Royal College of Nursing guidelines which stated that there should be 24 hour children's nurse presence in the department. Additionally, there were no advanced paediatric life support (APLS) qualified nurses in the department as required by the 2012 intercollegiate standards.
- The department had introduced a course called Airedale Paediatric Emergency Skills (APES) that trained qualified adult nurses to be able to treat children and young people in an emergency situation. Adult nurses who completed the course were trained to paediatric intermediate life support PILS) level. Of the 38 nurses in the department, 13 had up to date APES training, 16 had APES training booked within the next six months and nine had no current training or training booked.
- The course was accredited by the Royal college of Anaesthetists.
- The department carried out a BEST assessment of nurse staffing levels in January 2017. The BEST assessment recommended a significant increase in staffing numbers. The matron and senior nursing staff were working together to move staffing levels closer to the BEST recommendations. Planned and actual staffing levels were displayed in the department and updated on a daily basis.
- The department used bank and regular agency staff to try to fill any gaps in the rota.
- The department's bank and agency use between March 2016 and March 2017 was just under 5,200 hours. Bank or agency staff were used to cover shifts or partial shifts on 538 occasions.
- We looked at the planned and actual staffing levels on the department. From December 2016 to March 2017, the department statistics showed sufficient qualified staff on duty to meet the needs of patients however it was unclear whether this reflected when staff were asked to move to different departments or help out on wards. Between the same time period, the actual number of unqualified staff was 3 WTE less than the planned staff. We discussed whether this had an impact on patient care. Staff we spoke with were unable to give us specific examples of any patient impact however they spoke of times when the department had been understaffed or had poor skill mix. We saw that staff had reported staff shortages and skill mix as incidents on 33 occasions between January and December 2016.
- Staff told us that nurses from ED were often asked to cover shortages on other wards. Both nursing and medical staff raised concerns about this practice to us as it had made staff reluctant to cover extra shifts in ED since they were not guaranteed to be working in ED. Additionally, medical staff told us that there had been occasions when ED nurses had been sent to a ward and replaced in ED by a non ED nurse who did not always have the skills needed. Incident data supported concerns about staffing levels because of staff being sent to support wards.
- The results from the trust's 2015 staff survey for the ED showed that 64% of staff thought there were not enough staff within the organisation to do their job properly.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses.
- According to information provided to us by the trust, in January to March 2017 there was a nursing staff turnover rate of 15.2% and a vacancy rate of 4.5%. This equated to 1.6WTE vacancies.
- The management team told us about the action the department was taking to recruit new staff to the ED, including that a recent recruitment drive had secured a number of new nurses, all awaiting either HR checks or confirmation of qualification before they were able to start work as a registered nurse. At the time of the inspection, there was a 1.69WTE registered nurse vacancy. Three new nurses were due to start in the department in September post qualification. The management team showed how they were succession planning to ensure that there were no unexpected gaps in the workforce.
- There was an induction process in place and before agency staff were allocated to the department, they had to provide evidence of competency. The senior nurse in charge had to sign to say they were happy with the competencies of any bank staff used.

- We observed a board round between nurses and saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues.

Medical staffing

- Doctors staffed the department 24 hours per day seven days a week. ED consultant presence was also on site at least between 8am and midnight with on call access outside of these times. On occasions, consultant staff remained on site as resident on call if the department was busy or had a shortage of middle grade doctors on duty. Because of this, the department met the required standards for trauma units.
- The department had funding for 10 WTE consultants. At the time of inspection, there was a vacancy rate of 33%. There were seven WTE consultants employed in the department. Consultant sickness was low at less than 1% and turnover was at 20% (1.4WTE).
- Across the department there was a vacancy rate of 16% (4.05 WTE) and a sickness rate of 2.2%
- When we spoke with staff, they told us that there were three consultant vacancies. These were covered either by existing staff or locums.
- The department used medical locums to fill gaps in rotas. From February 2016 to January 2017 locum usage varied between 4% in March June, September, December and January, 8% in February, April, May, July and August and 12% in October.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- The trust reported to us that medical staff were fully up to date with revalidation requirements.

Major incident awareness and training

- The department had a consultant who took the lead on major incidents and trauma. The lead consultant held annual desk top exercises looking at how the department should manage a major incident. The department also took part in live practice scenarios to give staff experience of what to do in the case of a major incident.
- The ED at the Airedale Hospital was a trauma unit. This meant that patients who were unwell or had been involved in an accident or incident were brought to the department. Patients classed as being involved in a major trauma were taken to the closest major trauma centre.
- We checked the equipment the department held, to be used in the event of a major incident. We found that this was stored securely, organised and appropriately accessible. We found that the department had an ample supply of high visibility clothing, hard hats and torches.
- Staff in the department were aware of the role they would play, dealing with walking wounded if there was a major incident in the region.
- The department had a policy in place to manage patients presenting with suspected Ebola. There was sufficient equipment and a designated area of the department. Staff were aware of their roles and responsibilities in the event of a possible presentation.
- The department had business continuity plans in place, in the event of system failures.
- Security staff were based outside of the department, but were accessible if required however; staff gave us examples of when they have had to call the police over night because security staff were occupied with patients living with dementia.
- The department could be locked down easily to ensure the safety of patients should the need arise. Staff had recently locked down the department due to threats from and aggressive and violent patient with a knife. Staff were aware of their roles and responsibilities in such a situation and were debriefed after such events.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- The hospital had a clear vision, values and objectives and these were reflected in the department.
- There were governance processes in place to ensure that lessons were learned, guidance up to date and all staff made aware of complaints, incidents and changes in practice.
- Staff felt that the leadership in the department was strong, positive and supportive. Concerns were listened to and when possible addressed.
- There was a learning and supportive culture in the department. Staff worked together as a team and supported each other to ensure the wellbeing of patients.

- The department provided us with evidence of staff, patient and public engagement in relation to improving current services and developing future services.

However:

- We found the department to be reactive and responsive to dealing with problems and issues as they arose however not proactive in identifying potential problems and taking action to prevent them.

Vision and strategy for this service

- The hospital had a clear vision, strategic objectives and values underpinned by a mission statement and first principle. Staff we spoke with were fully aware of the vision and how the trust aimed to achieve it.
- The trust had a strategy for the service and was working with local clinical commissioning groups to develop urgent and emergency care services. This included the building of a new medical assessment and ambulatory care unit designed to ease pressure on beds in the ED.
- Staff were aware of the future development of the department as well as how enhanced working with other departments such as the ambulatory care unit would improve patient care and outcomes and make sure that the ED encountered fewer problems with bed management.
- The trust had developed a local strategy plan for the department with key areas of performance for improvement clearly identified.
- Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand.

Governance, risk management and quality measurement

- A clinical governance system was in place across the department. Staff were invited to attend clinical governance meetings and minutes were available for all staff to review. The meeting minutes provided evidence of discussions about the quality of care, incidents and complaints and detailed actions staff needed to take. Where applicable, staff created action logs that detailed timescales and responsible staff. These were regularly reviewed and monitored.
- Clinical governance meeting minutes showed that staff were actively taking part in clinical audit to ensure that clinical quality was maintained. For example, senior staff undertook regular reviews of patient records.
- We were assured the management team were made aware of all incidents, as there was a reporting culture amongst all staff. Staff we spoke with told us they reported incidents.
- There was a process in place to ensure that all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes. However, during our inspection we found that there were no standard operating procedures for sepsis in children or head injuries in children. When we spoke with a consultant about this, we were told that they were in development along with others for croup, bronchiolitis and fever. We would have expected these to already be in place within the department because they are conditions patients attend with regularly.
- The staff we spoke with were clear about the risks the department faced.
- There was a process in place for ensuring that the results of radiology investigations were followed up to ensure that any “missed abnormality” was followed up in a timely manner. Where abnormalities had been missed, staff involved were informed and offered support and training to ensure that the risk of future errors was minimised. Missed abnormality x-rays were also discussed at monthly governance meetings to ensure department wide learning.
- A departmental risk register was available and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department. These risks correlated with the risks we observed during our time in the department.
- When we spoke with the senior management team, they were clear about the risks posed to the department and how these were being addressed. Most mitigation was effective however; some risks such as staffing remained a concern.
- Managers discussed waiting time breaches regularly to identify any themes and were able to take actions to address issues, such as bed shortages across the trust.

Leadership of service

- A clinical lead, matron and business manager plus a senior sister who managed operational matters in the

department led the department. We met with the clinical, nursing, and business managers as part of our inspection. The team appeared to work well together to provide a cohesive management team.
- Staff told us that senior staff listened to concerns and wherever possible, took action.
- Staff told us that the matron was a visible presence in the department even though her caseload included a number of other departments in the trust. Staff told us they were confident that she always had the best interests of patients and staff at heart. Members of the executive team occasionally visited the department on walk-arounds. Staff told us they would recognise the clinical executive team and thought that they were accessible.
- Nursing staff told us that they felt well-led at a local level and that they had no concerns with their line managers. They felt that they could raise concerns and be confident that they would be resolved whenever possible in a timely manner. They told us that the management team was open, approachable and provided good leadership. We had no concerns about the senior department leadership team being unapproachable.

Culture within the service

- We spoke with a number of staff from different disciplines about the culture of the department. We received a consistent picture of staff being happy to work in the department. Staff said that colleagues were supportive of each other, cross discipline and across seniority. People described the department as friendly and a good team to work with. Some staff told us that they were given a choice about the department they could train in and they had actively chosen ED.
- The atmosphere in the department showed that staff focus was on treating patients in an efficient way. We also saw that senior staff were keen to support colleagues in their learning. We saw examples of medical staff explaining patient conditions and treatment to nurses in detail to assist with their learning.
- The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked as a team to ensure that patients received good care. Team members appeared to have a great rapport and although the department was busy, the atmosphere appeared calm and relaxed.
- Staff felt that their hard work was recognised and they felt appreciated by colleagues, line managers and senior management who didn't work in the department.

Public engagement

- The ED had a patient forum. The forum had a project plan. This detailed all of the patient engagement and experience activity being undertaken by the department. There were a number of initiatives being undertaken by the department.
- The department has worked alongside Healthwatch Bradford to identify ways to improve patient experience in the department. The Healthwatch Bradford report recommendations have been actioned and an action plan in place to improve patient experience.
- The department held focus groups for patients to attend to discuss their experiences and learn about how the department worked.
- The department took part in the Friends and Family Test and had performed better than the England average between January and December 2016.
- The trust had consulted with the public and local stakeholders about the building and configuration of the new ambulatory care department.

Staff engagement

- Staff told us that they felt listened to by colleagues and managers. Staff presented to us that managers were approachable and easy to engage with or express concerns to.
- The matron held regular open meetings where staff could talk openly and discuss the department and any worries they had.
- The trust undertook a staff survey in July 2015. The results highlighted a number of areas where staff were unhappy. Results for the ED showed that in 2015, 58% of staff came to work despite not feeling well enough, 41% went to work despite not feeling well enough to perform duties and 16% said they felt pressure to come to work from managers when they were not feeling well enough. Overall, however the survey results were more positive than the results from the 2014 survey. These were the most up to date staff satisfaction results given to us.

Urgent and emergency services

Innovation, improvement and sustainability

- The trust was working with local schools to educate young people about how to deal with an emergency medical situation.
- The paediatric waiting room had an interactive floor game to help distract young people whilst waiting for treatment.
- The department had developed an online safeguarding referral system. This meant that all staff could send the referral online rather than try to make phone calls and speak to the relevant people. This has led to referrals being made in a much timelier manner.
- The department had plans to employ primary care advanced nurse practitioners who would make sure that patients were seen by the most appropriate clinician.

Medical care (including older people's care)

Safe	Requires improvement
Well-led	Requires improvement
Overall	

Information about the service

Airedale NHS Foundation Trust provided NHS hospital and community services for a local population of over 200,000 across Yorkshire and Lancashire. The main hospital site, Airedale General Hospital (AGH), situated between Skipton and Keighley accommodated medical care services.

The medical care service at the trust provided care and treatment across cardiorespiratory, stroke services, neurological rehabilitation, haematology and oncology, older person's services, gastroenterology and diabetes. The trust reported a medical care bed base of 184 inpatient beds located across the acute medical unit (AMU – ward 2), ward 4, ward 5, ward 6, ward 7, ward 10, ward 15 and ward 18 (haematology beds, staffed by surgery) and coronary care beds on the critical care unit (CCU).

The trust had 27,983 medical admissions between November 2015 and October 2016. Emergency admissions accounted for 11,828 (42.3%), 533 (1.9%) were elective, and the remaining 15,622 (55.9%) were day case.

Admissions for the top three Medical specialties were:

- General medicine – 11,608
- Gastroenterology – 5,065
- Clinical haematology – 4,451

The service was comprehensively inspected in March 2016 where it was rated as good in the effective, caring and responsive key questions, however was rated as requires improvement in safe and well-led. This provided the service with an overall rating of 'requires improvement'.

The service was further visited in September 2016 with a focus around nurse staffing and the management of extra capacity beds/wards. We did not re-rate the service at this time.

During our inspection on 28-30 March and our unannounced visit on 12 April 2017, we focussed on the safe and well-led key questions only. We spoke with 48 members of staff (including managers, doctors, nurses, allied health professionals and support staff); we reviewed 20 sets of records including 14 electronic prescription charts. We spoke to 10 patients and family members/carers.

Medical care (including older people's care)

Summary of findings

The service was inspected as part of our comprehensive visit in March 2016. Overall, medical care at AGH was rated 'requires improvement'. A number of areas for improvement were highlighted and the service was told to take action to:

- Ensure nurse staffing levels were safe.
- Ensure mandatory training figures met trust target.
- Ensure observations and National Early Warning Scores (NEWS) were recorded in accordance with clinical need and best practice guidelines.
- Ensure evidence based guidelines were kept up-to-date.
- Ensure the divisional risk register was reviewed and current.

The service was also asked to consider:

- Mortality reviews to promote learning in this area.
- Displaying safety thermometer data consistently in a user friendly format.
- Reviewing the capacity within the Haematology and Oncology Day Unit (HODU).
- Reviewing record keeping and documentation standards.

The service was also visited in September 2016 where there was a focus on nurse staffing and the management of extra capacity beds/wards. The service was not re-rated during this unannounced inspection.

During our 2017 inspection, we found the service had made some improvements:

- Nurse staffing levels had improved however there was still vulnerability across the division due to vacancies and some shifts remaining unfilled.
- Mandatory training figures were good and on target to meet the trust benchmark.
- Observations, recording of NEWS scores and adherence to NEWS triggers was good.
- The divisional risk register still contained a number of historic risks and risk ratings tended to be low/ moderate. There was evidence of on-going review and actions taken.
- There were examples where care followed up-to-date evidence based guidelines.
- There were mortality reviews held across the divisional clinical specialities.
- Safety Thermometer data was consistently displayed in a user friendly format.
- The division had reviewed the capacity issues in HODU; however the demand for the service remained high rendering the current clinical environment unsuitable.
- Record keeping and documentation standards overall were good.

We rated medical care (including older people's care) for safe and well-led only.

These were rated as requires improvement because:

- Learning from incidents was not fully embedded and there were missed opportunities to share lessons to improve patient safety. There appeared to be an excessive number of incident reporting categories used to capture data and monitor themes and trends.
- Whilst there has been a reduction in patient harms, there continued to be a number of reported incidents classified as patient accidents, in particular, relating to falls and pressure ulcers.
- The clinical environment in the HODU was not fit to meet current capacity and demand issues resulting in care being delivered in overcrowded facilities.
- The clean and dirty utility facilities in the cardiac catheter lab were insufficient for the number of procedures performed. This led to waste being stored in any inappropriate area.
- The standard operating procedure for the opening and closing of extra capacity beds/wards was not always followed.
- Patients waiting in the cardiac catheter lab had no means to alert staff in the event of a care need or emergency.
- Nurse staffing remained vulnerable. There were periods of understaffing and inappropriate skill mix on some wards. The 'bleep holder' initiative to support escalation procedures in nurse staffing was not fully effective as it diverted a rostered ward based nurse away from existing ward-based responsibilities.
- There had been some changes within the group leadership team. The Head of Community Services

Medical care (including older people's care)

had extended her portfolio on an interim basis to assist the group whilst awaiting the appointment of a Head of Nursing. Additionally, the group had appointed an Interim General Manager to provide support during the capital programme and transformation work.

- The group were looking to strengthen triumvirates across the group and acknowledged there was work to do with clinical leads to address this. During this change, the current management team and clinical directors were enrolled to complete a clinical leadership programme during summer 2017. This would support service and leadership development to ensure local quality issues, divisional challenges and performance measures remained a priority. These changes needed time to settle and embed.
- The governance framework had been reviewed and some group names had been changed. Staff were not fully aware of the changes and the new quality group names.
- The divisional risk register provided risks back to 2012. The top three rated risks within the risk register did not mirror those reported by the leadership team. There were no group risks rated as 16 or above (high to very high category).
- Staff morale and satisfaction was mixed.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- Learning from incidents was not fully embedded and there were missed opportunities to share lessons to improve patient safety. There appeared to be an excessive number of incident reporting categories used to capture data and monitor themes and trends.
- Whilst there has been a reduction in patient harms, there continued to be a number of reported incidents classified as patient accidents, in particular, relating to falls and pressure ulcers.
- The division reported safety thermometer 'harm-free' care below the national attainment target of 95%.
- The clinical environment in the Haematology Oncology Day Unit was not fit to meet current capacity and demand issues resulting in care being delivered in overcrowded facilities at times. This resulted in poorer patient experience in some instances.
- The clean and dirty utility facilities in the cardiac catheter lab were insufficient for the number of procedures performed. This led to waste being stored in any inappropriate area.
- The standard operating procedure for the opening and closing of extra capacity beds/wards was not always followed.
- Patients waiting in the cardiac catheter lab had no means to alert staff in the event of a care need or emergency.
- Local medicines audits highlighted areas for improvement around medications in fridges and controlled drug standards. Additionally, we found the self-medication procedure was not followed.
- Local divisional medical record keeping audits reported limited compliance against essential medical documentation standards.
- Divisional involvement in the sepsis project reported poor compliance with the sepsis pathway and a variability in the timeliness of antibiotic administration.
- Nurse staffing remained vulnerable. There were periods of understaffing and inappropriate skill mix on some

wards. The 'bleep holder' initiative to support escalation procedures in nurse staffing was not fully effective as it diverted a rostered, ward-based nurse away from existing ward-based responsibilities.

However:

- Staff were confident in reporting incidents and understood incident reporting procedures.
- There had been a proactive effort to target key themes relating to patient harms, which had brought about some improvements in harm-free care. Safety thermometer data was displayed consistently on wards in a user friendly format.
- Clinical environments were visibly clean and there were cleaning schedules in place. Staff were aware of infection prevention and control procedures. Compliance against local cleanliness, infection control and hygiene audits was good across the division.
- All equipment checks met local policy standards, national guidelines and/or manufacturer recommendations.
- There were a number of robust procedures in place to support clinician response in the assessment and management of patient risk.

Incidents

- Between January 2016 and December 2016, the trust reported no incidents, which were classified as never events for medical care. 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 has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in medical care, which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these, the most common type of incident reported was slips/trips and falls with four out of the 12 incidents (33%).
- We reviewed three SI reports. These provided an executive summary of the incident, detailed the members of the investigation team, provided a background and chronology of events, addressed duty of candour, highlighted good practice, examined contributory factors, service delivery and root cause. The reports concluded with action plans (including responsible person, timescales and risk analysis), lessons to be learned and recommendations. The timeliness in completing the serious incident reviews was variable.
- National Reporting and Learning System (NRLS) data from January 2016 to December 2016 reported 2,094 incidents from medicine. These were categorised by degree of harm as no harm (72%), low harm (25%), moderate harm (2%) and severe/death/others (less than 1%). The top three reported incident types were patient accident (698), infrastructure including staffing, facilities and environment (362) and implementation of care and ongoing monitoring/review (287).
- NRLS data broadly correlated with trust provided figures which showed 2,482 incidents in medicine, categorised as no harm (66%), low harm (33%), moderate (1%) and severe/death/others (less than 1%). The top five reported incident types were staffing levels/issues (405), found on floor (295), slip/trip/fall (178), pressure ulcer category 2 – admitted (104) and pressure ulcer category 2 – hospital (104). The trust classified incidents in over 150 sub-categories.
- Staff confidently reported incidents and provided examples of incidents they would report. These primarily focussed on patient safety matters such as falls, pressure ulcers, near misses, medication errors and staffing deficiencies.
- Staff we spoke to knew of the Duty of Candour (DoC) requirements and of the trust being open policy. Junior staff understood that this involved being 'open and honest' with patients. Ward leaders were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families as part of the trust procedures.
- The division considered learning from incidents and when things went wrong. Management discussed outcomes at divisional meetings, matrons and ward leaders shared learning and cascaded key information to their staff at ward meetings and at safety huddles. Ward staff informed us feedback from reported incidents was variable and not always shared on their wards.
- The division held monthly mortality and morbidity (M&M) review meetings within clinical specialisms, which were well attended. The meetings reviewed case

summaries presented, reviewed outcomes and identified key lessons. Ward leader informed us that outcomes from the M&M group (where relevant to their area) were discussed at ward meetings.

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.
- Wards displayed safety thermometer data consistently in a user-friendly format for public review which had changed from the previous inspection. The wards also displayed data detailing harm-free days or number of days since the last patient safety event.
- Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers (PUs), 29 falls with harm and 15 new catheter urinary tract infections (CUTIs) between January 2016 and January 2017.
- The prevalence rate of pressure ulcers had fluctuated over the 13-month period, peaking in June 2016, September 2016 and December 2016. The division reported 474 PUs between February 2016 and January 2017 of which 178 (38%) were hospital acquired. The majority of these (74%) were classified as category 2 (defined as 'partial thickness loss of dermis presenting as a shallow open ulcer' – European Pressure Ulcer Advisory Panel). The highest incidence was reported from ward 2 (AMU) and ward 4 respectively. There was one category four PU reported as hospital acquired. The incidence of pressure ulcer prevalence had reduced from four per 1000 OBDs (occupied bed days) in April 2016 to an average rate of two per 1000 OBDs in February 2017. There had been a reduction of 50**%** from the previous 12 months.
- The Tissue Viability Nurse (TVN) and Patient Safety team had led the PU reduction initiatives. These had included improved surveillance and reporting, targeted education, the purchase of new pressure relieving equipment such as gel cushions and higher specification mattresses, reinforcement of risk assessments and intentional rounding documentation.
- In the 2015 National Audit of Inpatient Falls (NAIF), the trust reported the highest number of falls per 1000 OBDs across the Yorkshire and Humber Region (as 11.14) and the fourth highest resulting in moderate or severe harm (as 0.24).
- The trust responded to the NAIF outcomes and the division had embraced a number of the Falls Improvement Group initiatives. These were targeted on high-risk patient cohorts (for example, those living with dementia), considering multi-factorial elements such as medical causes, environmental causes and raising staff awareness. The division implemented enhanced supervision pathways, increased the use of sensors and mobility aids, implemented safety huddles on wards and 'falls' rounds. Ward leaders received adverse event reports covering falls data (AEFs) and these shared themes and investigation outcomes were discussed at safety huddles. Ward 4 won the hospital 'ward of the year' for falls reduction work, which included a detailed local falls analysis, multi-disciplinary team (MDT) approach to falls reduction with therapists and involvement of family and carers.
- The prevalence rate of falls increased from January to March 2016; however since July 2016 there has been an overall decrease in the prevalence rate. The local monitored prevalence rate was recorded at less than eight falls per 1000 OBDs, showing an improvement on the 2015 NAIF data.
- The rate of CUTIs fluctuated over the 12-month period; August 2016 reported the highest prevalence rate.
- Overall, the division averaged 92% harm free care against a target of 95%. There had been an improvement in harm free care recorded compared to the 2015/16 data.

Cleanliness, infection control and hygiene

- The division followed the trust infection control procedures that were aligned to national guidelines for hospital-associated infections (HCAI) and infection prevention and control (IPC) best practice.
- The IPC service involving specialist nurses and microbiology staff provided a seven-day service.
- All wards we visited were visibly clean and tidy.
- The division were involved in trust wide IPC audit activity.
- This included monthly cleaning audits checking clinical and non-clinical areas against cleanliness standards. Each area was rated (using a red/amber/green rating) in

accordance with compliance against clinical standards. All areas reported overall performance in excess of the division benchmark of 90%. Where auditors identified areas for improvement, these were highlighted to the ward leader and housekeeper to rectify and were re-inspected during the follow up audit.

- Wards displayed cleaning schedules detailing the frequency and nature of the clean to be performed in clinical and non-clinical areas. "I am clean" stickers were used following equipment cleaning to confirm the item was safe and suitable for patient use.
- The division used a Clostridium difficile (C. difficile) infection assessment tool and action plan to monitor cases using twelve categories such as isolation, sampling, use of antimicrobials, environmental factors and lessons learned. Between April 2016 and February 2017, the division reported 10 cases of C. difficile of which two were deemed avoidable.
- Hand hygiene audits from January 2016 to January 2017 showed good compliance, averaging 95% to 99% overall across the division. There was a variance throughout the division and where wards failed to achieve the target of 95% in any given reporting period, auditors discussed this with the respective ward leader. Ward leaders followed up audit findings with individual staff members and collectively at safety huddles and through ward communications.
- The division aligned to the national zero tolerance policy for avoidable Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections. The division reported two cases in 2016/17, with no reported cases since June 2016.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "bare below the elbow" protocol. Staff used personal protective equipment (PPE) such as disposable gloves and gowns where appropriate.
- Staff informed us of the procedure when caring for patients who required isolation for IPC measures.
- Staff segregated waste and disposed of sharps in accordance with local IPC policy.
- A local Healthwatch visit dated September 2016 reported positive findings on ward cleanliness across the division.
- The endoscopy unit had an on-site decontamination facility for scoping equipment, which met national standards (Joint Advisory Group on Gastrointestinal Endoscopy - JAG).

Environment and equipment

- The divisional wards were situated in the main hospital building at AGH. There had been investment to improve internal facilities including upgrade in furnishings and fittings on the wards.
- All patients had designated bed space, which included a personal locker, table, call bell and access to gender specific toileting and bathing facilities.
- We checked the resuscitation trolleys on all the wards we visited and these contained correct stock. Staff checked the electrical equipment daily (defibrillator and portable suction/oxygen) and after use. Staff completed fuller weekly content checks of all stock including emergency drug expiry dates. We saw each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly. Trolleys were fitted with a tamper proof tag.
- All equipment we checked had safety-testing stickers in date, which assured staff the equipment used was safe, and fit for purpose. Staff confirmed where equipment had not been routinely checked; they ceased to use it until they received approval from the Estates department.
- The trust had an equipment maintenance assurance log to record inspection due dates, last inspection dates and repairs.
- A local Healthwatch report dated September 2016 highlighted some environmental issues on ward 5. These recommendations were to improve patient safety by improving visibility of bays, conversion of a day room to dining area, the addition of an assessment bathroom and improving signage and decorations for vulnerable patient groups.
- On ward 1 (super surge ward), managers completed an environmental check as part of the ward opening and closing procedure prior to patients arriving to ensure the ward was suitably equipped. The ward leader completed daily environmental checks to ensure the

ward continued to meet the needs of the numbers of patients allocated to the ward. The standard operating procedure for this purpose was not always followed out-of-hours or in the ward leaders absence.

- The HODU provided day-care services on their unit comprising 19 treatment chairs in a lounge area and four treatment rooms. The unit cared for an average of 35-45 patients daily between Monday to Friday. The unit also provided care to non-appointed patients on an emergency basis. The unit environment was too small for the demand placed upon it, which was particularly apparent during peak treatment times. There was insufficient space in between patients, the lounge area was cluttered with infusion machines and there was no suitable space where patients could be supported by family members or carers. A patient and their carer commented on the lounge area being very overcrowded and hot.
- In the cardiac catheter lab, clinical waste was stored in an open 'waste room' situated in the corridor. The same room housed electronic equipment, computer hardware and patient records stored on CD-ROMs. Staff confirmed the room often became full which caused door opening and closing to become restricted. The unit manager confirmed the 'waste room' door should be locked when not in use and we observed this to be secure during our unannounced visit.
- The cardiorespiratory planned investigation unit provided in-patient and out-patient facilities for echocardiogram (ECHO) testing, pacemaker checks, pulmonary function testing, stress tests and Doppler tests. The division recently purchased new stress testing and ECHO equipment. All equipment was checked in accordance with manufacturers and local testing arrangements.
- The endoscopy unit received Joint Advisory Group on Gastrointestinal Endoscopy ("JAG") accreditation in February 2017. This accreditation is formal recognition of competence against national standards in endoscopy care including environmental factors, equipment and patient outcomes.
- The trust had secured funds to develop a new Acute Admissions Unit, which is due for completion in April 2018. In addition, separate funding is in place to support the development of CCU on Ward 1. The intention is that CCU will be relocated from its position on Ward 16 to a new Integrated Cardiac Unit, Ward 1. This is scheduled to be opened July 2017.

Medicines

- Overall, we found medicines were managed safely in line with local and national requirements.
- All divisional wards were audited annually (or more often by exception) by the Lead Pharmacist for Clinical Governance . All wards complied with the 14 audit standards for the safe handling of medicines. The auditor highlighted some minor exceptions and these themed around medicines stored in the medicines fridge having a date opened and an expiry date noted along with some daily fridge temperature recordings missing. These observations formed the basis of local actions plans followed up the respective ward leader.
- The Lead Pharmacist audited the safe handling and storage of controlled drugs (CDs) against 29 standards, as part of the 'Annual CD Audit'. Overall, compliance across divisional wards was good. The auditor highlighted some observations around accuracy of stock checks, missing daily balance checks, ordering and receipt administration, recording of destruction and some signature omissions. Auditors made recommendations and discussed these with clinical leads and respective ward leader.
- The pharmacy team spoke to two patients and looked at 14 sets of records. Patients were given their medicines in a timely way, as prescribed, including pain relief. Allergies were clearly documented. Medicines records were completed using an Electronic Prescribing and Medicines Administration (EPMA) system. This system was effectively used by nursing staff to administer and record medicines. We observed how the system was used by the nurse in charge to check medicines were administered at the correct times.
- Medicines were stored in line with trust policy including medicines, which required refrigeration including chemotherapy.
- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored with access restricted to authorised staff, and accurate records were maintained. Balance checks were performed regularly in line with the trust policy on the five divisional wards visited. We checked medicines and equipment for emergency use we found these were stored securely and a procedure was in place to ensure they were fit for purpose.

- We identified two patients who were self-administering medicines. The trust had a self-administration policy, but staff were not following this because they had not assessed each person's ability to safely administer their own medicines. This meant we could not be sure people were being supported to look after their own medicines safely.
- The pharmacy provided a medicines reconciliation and discharge service across all medical wards with both dedicated technicians and pharmacists. We were provided with figures, which showed that more than 80% of patients were seen within 24 hours. However, during our visit, we identified three patients with discrepancies on their medicines charts and no entries had been made in their notes. One patient had not been seen by a pharmacist for nine days and outstanding actions, which had been identified on admission, had not been followed up.
- The ward leader completed the ward closing procedure on ward 1 which involved the returning of medicines to pharmacy however fridge stored medications were not returned. When the ward was closed, fridge temperatures were not recorded therefore potentially compromising the safety and efficacy of the medications stored therein. However the trust had processes and protocols in place to ensure the safety and efficacy of fridge stored medicines during the closure of Ward 1.

Records

- Nursing and medical records were stored safely in locked trolleys or in staffed areas.
- The division recorded relevant clinical patient information in paper records and a number of aligned documents such as investigations and test results were stored in an electronic patient record (EPR).
- Where paper records were being used, these were generally in a good state of order however, it was not always easy to readily identify the document required for review.
- The division had developed a number of care bundles and specialist care pathway documentation following best practice guidelines, such as the neutropenic sepsis and ambulatory care pathways.
- The division took part in the trust 'Take5' initiative to review patient records to ensure compliance against key record keeping and documentation standards.
- The division completed a National Early Warning Score ("NEWS") 'Take5' audit where senior staff reviewed five patient records every month to ensure calculations, escalation and response was appropriate to clinical need. Audit outcomes and compliance with indicators were good
- The division also completed a 'Take5' focus on Intentional Rounding, which highlighted good compliance across the division against 19 key questions.
- Senior nurses completed monthly audit checks against key documentation performance indicators such as nutrition, pressure ulcers, fluid balance, risk assessments and intentional rounding. Auditors found compliance against the key domains was variable, however it was mostly good. On ward 4 for example, 11 of the 14 criterion considered were in excess of 80% compliance. Ward 5 fell below 80% on one of the criteria, ward 6 in two and ward 7 short in three. An analysis of audit findings highlighted intentional rounding and completion of fluid balance charts to require improvement.
- We reviewed 20 sets of patient records (including nursing, medical and MDT entries). Overall, documentation standards were good. We found key risk assessments (falls, PUs, MUST, VTE) to be completed for all patients (100%). However, there was a variable completion of reassessment of risk; we found three records (15%) where an updated risk assessment was overdue or absent.
- We found MDT involvement in care, consent issues considered and documentation confirming patient involvement in care decisions.
- Staff completed fluid, intentional round and observation charts including NEWS scores in a timely manner and in accordance with clinical need. We found escalation triggers followed in accordance with NEWS standards had improved from our previous inspection. All entries were legible, dated and signed.
- The division took part in the trust wide Annual Medical Record Keeping Audit 2016 which focussed on 33 essential medical record keeping standards. Standards covered items such as notes administration, legibility, evidence of diagnoses, plan of care, consent, reviews, discharge planning and communication with GPs. Auditors found the division fully compliant in 27% of the standards, partially compliant in 33% and non-compliant in 39%. The lowest scored ratings

aligned to author's writing their name and designation with corresponding entries. Auditors had presented results to the Senior Leadership Team and Clinical Directors.

- The endoscopy unit completed quarterly variance audits to demonstrate and evaluate the effectiveness of care provided to patients in the unit. The audit considered various key performance indicators including care pathway record keeping and documentation. Overall, record keeping was found to be good and best practice guidelines aligned to JAG (Joint Advisory Group on Gastrointestinal Endoscopy) recommendations were reinforced.

Safeguarding

- The trust had a designated lead and responsible team for safeguarding across the organisation.
- Staff were aware of the safeguarding policy and accessed safeguarding information and key documents on the intranet. Staff were confident in identifying concerns and escalating in and out-of-hours.
- The trust set a target of 80% for completion of safeguarding training. 83% of medical staff and 96% nursing staff had completed safeguarding adult's level 1 mandatory training.
- The safeguarding team completed live and retrospective audits of patient records to ensure appropriate screening had been completed. This allowed auditors to identify potential trends or themes in safe care provision and for learning opportunities. Auditors found overall compliance against safeguarding indicators was good.

Mandatory training

- The trust set a target of 80% for completion of mandatory training. The fire safety course is a statutory training module the target for this is 75%.
- Mandatory training modules were listed as IPC (Level 1 and 2), blood transfusion, dementia awareness, equality and diversity, basic life support, conflict resolution, fire safety, manual handling (people and object) and information governance.
- A breakdown of compliance for mandatory courses as of 31 January 2017 for medical/dental and nursing/ midwifery staff in medical care varied. The medical and dental staffing group had met the trust target set for four out of 11 mandatory training courses, namely IPC (Level 1), blood transfusion, dementia awareness and equality and diversity. Compliance in other modules ranged from 50% to 78%.
- The nursing and midwifery staffing group had met the trust target set for nine out of 11 mandatory training courses. Manual handling compliance data was not provided for the division overall, however data by individual ward showed variable compliance between 75% and 100%.
- Mandatory training capture and compliance was ongoing for the 2016/17 year. All staff members not compliant with aspects of mandatory training were being booked onto courses to bring them up-to-date.

Assessing and responding to patient risk

- Staff used various tools to assess, monitor and respond to patient risk.
- Senior nurses audited key performance indicators relevant to patient risk. Auditors found NEWS compliance (the recording of clinical observations and responses to escalation triggers) on divisional wards against the nine criteria was good. All wards audited reported averaged compliance in excess of 95%.
- The division was involved in the audit of acutely ill patients in hospital (National Institute for Health and Care Excellence Clinical Guidance number 50 - NICE CG50). 50 patients from medicine (including older person's services) were audited. Overall, findings were positive with 96% of patients having clear written management plans. However, only 42% of these plans included interventions required in the event of an acute deterioration. The audit identified three key recommendations – medical staff to be reminded to include interventions when deterioration occurs, the recording of vital signs must be at least 12 hourly and frequency should be documented and the implementation of the use of rehabilitation prescriptions.
- As part of the trust Clinical Audit Project 2016/17, the division took part in the Sepsis Project to review diagnosis, misdiagnosis and timeliness of antibiotic administration. Audit findings confirmed the accuracy of diagnosing sepsis was good; however, there was variability in the timeliness of antibiotic administration. Additionally, the formal utilisation of the sepsis pathway was poor. The Clinical Director for Acute Medicine was informed of the findings and recommendations around

educational awareness regarding sepsis diagnosis, a revision to current pathways to reflect changes in the criteria for sepsis; a further review to understand the reasons of poor compliance with the current sepsis pathway and a re-audit was planned later in 2017. These findings broadly correlated with Sepsis CQUIN data reported by the trust.

- On wards where patients were being monitored by telemetry (remote cardiac monitoring), staff held a bleep for direct contact from CCU in the event of a change in a patient's cardiac rhythm. Wards also had a 'hot-phone' solely for contact to/from CCU. This had improved safety and communications identified during our previous inspection.
- The division opened a super surge ward (ward 1) when demand on beds and clinical need required. The division developed a ward opening and closing standard operating procedure to ensure the ward was suitably prepared in advance of any patient arrival. This included key equipment checks, linen, catering and staffing.
- On AMU, the nursing and medical team held daily huddles prior to and after shift handover. This allowed staff to complete a safety checklist to prioritise patient care for those newly admitted to the unit. The prompt prioritisation of patient need allowed the Frailty Elderly Pathway (FEP) team to respond to the needs of vulnerable older persons earlier.
- The FEP team primarily focussed on AMU where they assessed older persons using the Bournemouth Criteria (tool to assess those patients who would benefit from care under the frailty pathway) and comprehensive geriatric assessment. The team categorised patients according to risk and clinical need using the FEP scale (1-3 being those patients fit for discharge to those requiring longer-term care). The team liaised with all disciplines to assess care risks, promote rehabilitation and independence and address social aspects of care need to ensure patients received care in the right environment.
- The ambulatory care unit (ward 15) had written pathways for their patient cohort to reduce risk and to ensure attending patients received the right care in the right place. These pathways included treatment plans for deep vein thrombosis (DVT) and pulmonary embolism (PE) care, pleural effusion, anaemia, chest infections and chest pain.
- In stroke services, the consultants identified patients requiring thrombolysis to ensure prompt transfer to the centre at Bradford.
- In the cardiac catheter lab, patients waited in the adjacent corridor to be received by the catheter lab staff. There was no facility for patients waiting to contact staff in the event of a care need or emergency.
- Divisional wards had reviewed their ward layout to ensure those patients more vulnerable and at risk were cared for in areas of better visibility and located near to staff bases.
- The HODU had adopted the UK Oncology Nursing Society (UKONS) 24 Hour Triage Rapid Assessment and Access Toolkit to provide safe assessment for patients receiving cancer treatments who require advice and guidance out-of-hours. The triage log addressed key clinical concerns such as chest pain, breathing difficulties, sepsis, nausea and vomiting, infection and vascular line efficiency. This service was provided by way of a 24-hour helpline and staff signposted patients according to clinical need.
- The division accessed the trust wide Acute Care Team (ACT), in and out of hours, to provide clinical support when escalation issues or patient deterioration occurred. Staff commented ACT were accessible and responsive at all times.
- Ward 7 used easily identifiable yellow stickers in notes completed at end of each shift as a checklist to confirm patient safety checks completed covering falls, PUs, nutrition, urine check, cannula check and patient wristband being used.
- To reduce patient risk and environmental conflict, many wards had been decorated to a 'dementia friendly' standard with colour coordinated and identifiable bays, pictorial signage and various distraction therapies. This was particularly well demonstrated on ward 10.
- Staff reviewed medical patients being cared for on non-medical wards regularly. This allowed for early identification of changing care needs or deterioration.
- The endoscopy service provided a 24 hours a day and seven days a week acute rota for patients who may deteriorate because of gastrointestinal bleeding.

Nursing staffing

- The division provided information and data on nurse staffing.
- The division confirmed they undertook a six monthly review of nurse staffing within the inpatient wards

through the completion of the Safer Nursing Care Tool (SNCT), The division applied standard staffing calculations to all appropriate areas within medicine (except AMU which apply the calculations directed on the Shelford website for Acute Medical Units). The SNCT was used in conjunction with professional judgement and RCN staffing guidelines.

- The division reported planned qualified nurse (RNs) to patient ratios in the general medical wards aimed to achieve 1:8 during the day and 1:15 during the night. They reported AMU currently has a ratio during the day of 1:6 and overnight as 1:7.5 (including a coordinator role). The division added, whilst there was no tool to determine the staffing ratios within CCU, the nurse to patient ratio is 1:4, in line with national standards for CCU.
- The management team had identified nurse staffing as an issue within the medical division and this appeared on the services risk register.
- We reviewed nurse staffing fill rates and nurse staffing ward rotas (covering December 2016 to March 2017). Between December 2016 and March 2017, all wards had RN shifts unfilled each week. Where RN shifts were unfilled by existing staff, bank or agency, the service tried to backfill with additional HCA numbers.
- Based on establishment planned RN figures during this period and a three shift per day rota system (comprising early, late and night shifts totalling 21 shifts per week), we found the numbers of shifts where RN complement was less than establishment planned figures ranged between one and nine shifts per week. This meant there was a shortfall in RN staffing against establishment figures on up to 43% of shifts.
- This shortfall broadly correlated with vacancy rates, fill rates and nurse commentary regarding staffing concerns.

Ward 1 – 'Super Surge'

- Fill rates provided were inaccurate due to the intermittent nature of the ward opening and closing, and the variability in patient numbers. Staff covering ward 1 were from the existing trust-staffing complement and supplemented by bank and agency staff. Figures provided reported average RN fill rates during the day at 83% and 70% overnight. Healthcare assistant (HCA) fill rates complemented the RN base, averaging over 95%. During March 2017, RN to patient ratios ranged from 1:4 to 1:15 based on days/shifts the ward was open.

Ward 2 – Acute Medical Unit (AMU)

- Ward 2 (AMU) provided a bed base for 44 patients. RN fill rates averaged 84% during the day and 93% overnight complemented by HCA fill at 110% and 120% overnight. This provided RN to patient ratios ranging from 1:5 to 1:8. The unit regularly had RN shifts unfilled due to vacancy numbers (equating to 17 WTE) and lack of interest from nurse bank and agency workers.

Ward 4 – General Medicine

- Ward 4 was a 30-bedded general medical ward. The ward reported no RN vacancies however; four staff members were awaiting NMC registration personal identification number (PIN). The ward was one RN short on day of visit providing a RN to patient ratio of 1:7:5. Fill rates reported average RN cover to be 90% on days and nights complemented by HCA support in excess of 130%. Review of historic nursing rotas showed shifts remaining unfilled despite escalation measures.

Ward 5 – Stroke/General Medicine

- Ward 5 provided care for 28 patients albeit the ward was established as a bed base of 22. The ward leader confirmed the additional six beds were to support current demand. The ward was one RN short on the day of our inspection providing for a RN to patient ratio of 1:9. Reviewing historic nurse rotas showed a number of RN shifts unfilled which corresponded to average RN fill rates of 75% during the day and 100% at night complimented by additional HCA staff at 102% during the day and 125% overnight.

Ward 6 – Older Persons/General Medicine

- Ward 6 provided care to 30 patients. The ward was one RN short during day and overnight on the day of our visit. The ward was also short of one HCA for the same period. This aligned with four current RN vacancies. This provided RN ratios of 1:10. Historic review of nursing rotas showed frequent unfilled RN shifts. This equated to average RN fill rates of 93% during the day and 100% overnight complemented by HCAs at 95% during the day and 118% overnight.

Ward 7 – Respiratory/Cardiology

- Ward 7 provided a bed base for 30 beds (including those patients requiring non-invasive ventilation - NIV). The ward reported three RN vacancies providing average RN

fill rates of 95% during the day and 100% overnight and ratios ranging from 1:7.5 to 1:15. Whilst there were no patients receiving NIV care at the time of our visit, staff stated they were unable to provide the necessary 1:2 ratio in the acute phase (guidelines provided by British Thoracic Society) however they obtained support from ACT and the on-call physiotherapist when required.

Ward 10 – Intermediate Care Ward

- Ward 10 was a recently converted extra capacity ward now providing intermediate care for 30 patients. The ward was in the process of recruiting to full complement however reported four current RN vacancies. Fill rates aligned to the vacancies averaging 88% RN cover during the day and 99% overnight complimented by HCA fill at 105%. RN to patient ratios ranged from 1:7.5 to 1:15 overnight.

Ward 15 – Ambulatory Care Unit

- Ward 15 was previously being used as an extra capacity ward however had recently been converted to house the divisional ambulatory care unit. Staffing on the unit was good and there were no staffing vacancies.
- All wards followed the trust escalation policy. The processes underpinning the request for additional nurse staffing included ward based staff working additional hours, reconfiguration of off duty to cover shift shortfalls, movement of staff from better staffed areas, use of bank and agency nurses requested through e-rostering system and via the 'bleep holder' and escalation to the matron. The 'bleep holder' was a divisional ward leader who was responsible for managing ward staffing issues and was supported by the matrons, and the bed management team.
- Ward leaders who had 'bleep holder' responsibility felt this weakened their own staffing establishment and distracted them from their own ward duties (where they were rostered to work) and did not feel they were best positioned to comment on wider directorate staffing issues without divisional oversight.
- There was a pattern of unfilled RN shifts most days on most wards. Staff commented how they would be moved around to help support lesser staffed areas. Staff considered safe staffing was being maintained out of the goodwill of existing staff working flexibly and additional hours to support the division. Staff reported this goodwill was having a bearing on their morale and wellbeing. It was also added by staff that they often missed mentorship/preceptorship/managerial time due to inadequate staffing levels.
- Between March 2016 and January 2017, the trust reported an average vacancy rate by department of 6%, a turnover rate of 17%, a sickness rate of 5% and bank and agency use at 2.9%.
- Nurse staffing and patient acuity was considered at daily bed meetings attended by matrons, bleep holders and divisional managers. The bed management team rated ward-staffing levels and aligned risk using a red/amber/green ("RAG") risk. There was no criterion for the RAG classification; this was based on professional judgment.

Medical staffing

- We reviewed medical staffing rotas and had the opportunity to speak with medical staff of all grades of seniority.
- Medical staffing across the division varied between the acute ward base and the general ward base.
- The proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.
- On AMU, the division reported a total of 21 hours consultant time per day on-site cover provided by three acute physicians on a rolling rota during Monday to Friday. This was broken down with two consultants on site for the post-take ward round until 1pm then supported by a third consultant who remained on-site until 9pm. Overnight consultant cover was provided by the general physician on-call from home. At the weekend, there is a total of 20 hours per day on-site cover provided by three consultants following the post-take ward round timings as per weekdays with presence on site until 6pm. The senior medical staff were supported by middle grade, junior grade doctors and advanced nurse practitioners during the day. Overnight, the unit had a specialist registrar (SpR) and three foundation year two doctors.
- The non-acute specialist consultants and general medical consultants provided cover for the base wards aligned to their specialism and covered the base wards overnight, on-call from home.

Medical care (including older people's care)

- Dependent on specialty, but generally, there were three consultant delivered ward rounds per week (Monday-Friday) on each ward plus one or two SpR delivered ward rounds per week, along with a minimum of two junior doctors per ward per day until 6pm.
- During the evening and at weekends, medical cover was provided by the SpR bleep holder (on AMU) and the consultant on call for AMU supported by ACT.
- The trust operated a 'Hospital at Night' (H@N) service out of hours from 8.30pm until 8.30am. The core resident H@N team members were the medical SpR, the resident junior doctor (or GP trainee), Advanced Clinical Practitioners, ACT nurses & HCAs.
- Between March 2016 and January 2017, the trust reported a vacancy rate by reporting unit of 1%, turnover rates of 35%, average sickness rates of 2% and locum usage of 6.4%.
- We were provided with sight of weekly medical rotas from December 2016 to March 2017. These showed senior and junior medical cover for all clinical areas across the division covering 24 hours a day and seven days a week.
- Junior medical staff reported on-call to be busy, but never unsafe. They confirmed they received sound clinical support from middle and senior grades.

Major incident awareness and training

- The trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke knew how to access the major incident policies for guidance.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.
- The trust Resilience Team carried out simulation exercises to challenge emergency response procedures and communications from the team were shared with staff.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There had been changes within the group leadership team. The Head of Community Services had extended her portfolio on an interim basis to assist the group whilst awaiting the appointment of a Head of Nursing. Additionally, the group had appointed an Interim General Manager to provide support during the capital programme and transformation work.
- The group were looking to strengthen triumvirates across the group and acknowledged there was work to do with clinical leads to address this. During this change, the current management team and clinical directors were enrolled to complete a clinical leadership programme during summer 2017. This would support service and leadership development to ensure local quality issues, divisional challenges and performance measures remained a priority. These changes needed time to settle and embed.
- Staff reported support from clinical matrons was variable across the division.
- The governance framework had been reviewed and some group names had been changed. Staff were not fully aware of the changes and the new quality group names .
- The divisional risk register provided risks back to 2012. The top three rated risks within the risk register did not mirror those reported by the leadership team. There were no group risks rated as 16 or above (high to very high category .
- Staff morale and satisfaction was mixed.

However:

- There was vision and strategy for the service aligned to trust objectives. There was a focus on quality and safety issues.
- The leadership team and managers were aware of their roles and responsibilities within the governance framework. The service had a divisional governance lead.
- Staff considered there had been a positive shift in the organisational culture in the past 12 months. Staff considered the leadership team and line managers to be more visible, approachable and receptive to concerns.
- There had been an effort in staff and public engagement activity.

- There had been some improvement projects progressed within the division to improve patient outcomes and promote service development. In particular, the FEP service was an exceptional example of this process.

Leadership of service

- The division had a defined management structure within the Integrated Care Group. This provided a structure detailing lines of accountability and responsibility within the divisional framework.
- The divisional leadership team had been through some changes recently and a number of interim appointments had been made to support the leadership team.
- The 'triumvirate' currently consisted of four Clinical Directors, a Senior Matron and a General Manager for Integrated Care. We were also informed of support provided by an Emergency and Resilience Planning Officer. The future plans for the triumvirate structure included the post of Associate Medical Director. However, this post was planned for 2018.
- The leadership team was supported by clinical leads across the specialities, four matrons and two patient service managers. Therapies and community services were supported by a range of Band 7 and 8a positions.
- The leadership team had an awareness of the current challenges and pressures faced by the division, however with some of the team recently appointed, they required time to develop a fuller understanding of the organisational and divisional priorities.
- The leadership team spoke proudly of the organisation, of the divisional staff and the care delivered in often challenging circumstances.
- Staff were gaining confidence in the leadership team. Staff told us the executive team had become more visible and were engaging more with staff at ward level. Staff commented positively about the Interim Director of Nursing and the Interim Head of Nursing appointees.
- Staff commented on the variability of clinical support provided by the matrons.
- Ward leaders considered themselves part of the ward team and were committed to ensure patient needs were met in safe environment and staff were supported to deliver the right care.
- The leadership team recognised the need to develop necessary skills, attributes and qualities to keep abreast of challenges faced in the organisation. The trust had secured external leadership training which was planned for the summer 2017.

Vision and strategy for this service

- The medicine service was part of the Integrated Care Group.
- The divisional vision aligned to the overarching trust 'first principle' of being "here to care". The division mirrored the trust vision of delivering the right care by aligning the governance pillars of quality, service, people and innovation underpinning the values and leadership.
- The divisional service strategy identified priorities for the group in the coming financial year. The strategy was reported to the Trust Board in November 2016. This identified proposed service strategy changes with associated financial impact, quality impact and productivity impact. These included expansion of ambulatory care pathways, consideration of an integrated workforce to support AMU, growth in cardiology functions, improving SAFER care bundles and consideration of new models of care (complex care, diabetes and accountable care systems).
- Strategic issues were discussed at the General Internal Medicine Business Meeting held monthly.

Governance, risk management and quality measurement

- The clinical group had adopted the new trust wide governance framework, which had been reviewed by external parties, namely NHS Improvement (NHSI) and a healthcare intelligence and quality improvement organisation.
- The clinical group framework provided governance channels into the wider organisational management structure. The leadership team recognised group governance needed to be clinically driven with multi-specialism input. The leadership team proposed to replicate the triumvirate template in all clinical specialisms and at ward level to reinforce the group structure .
- We met with senior members of staff who told us about their role and the structure of governance arrangements. Medicine services were part of the Integrated Care group. There was an overall governance

lead. The framework was devised to support the 'Ward to Board' ethos. Staff commented how there were several layers of governance before an issue could be signed off at senior level. Leaders added this ensured issues and learning was communicated throughout the group and allowed for the identification of any developing themes or trends across the group requiring attention .

- Wards had their individual governance meetings, which fed into the speciality governance meetings; these in turn fed into the overarching monthly medical governance meetings. At this level, the group looked at serious incidents, root cause analysis (RCA) investigations, complaints, and audit compliance. This group then fed into the integrated care governance meetings. They reported to the Delivery Assurance Group (DAG), who reported to the Executive Assurance Group (EAG). The final level was the Quality Assurance Group (known as QUAG).
- Senior staff also told us 'triumvirate' meetings took place every two weeks, which were attended by clinical directors, the general manager, governance managers, the head of integrated care and a matron. At these meetings, new complaints, serious incidents and other structural improvement work took place.
- Senior managers told us they had developed 'tracker tools' to monitor the progress of complaints, claims, RCA's, audits, and clinical guidance. They told us this additional assurance helped track when policies or guidance was due for update. Policy authors had six months advance notice to bring them up to date.
- The division held Medicine Governance meetings on a monthly basis. These meetings were well attended by senior staff and followed a set agenda covering action logs, learning from events (including mortality reviews and incidents), complaints, audit, divisional risks, dashboard data, policies, NICE guidelines and patient stories. The meeting minutes were comprehensive and detailed actions taken.
- The Group provided us with the Medical Service Risk Register. This comprised 44 identified risks dating from 2012 (anaphylaxis assessment) to the current time. All risks had review dates, risk owners and a risk rating. The top three risks rated were nurse staffing (risk rated as 15), safe management of patients on non-invasive ventilation (NIV) and failure to maintain required room temperatures in clean utility areas (both risk rated as 12). There were no risks considered to be at a rating above 15.
- The leadership team considered their top three risks to be nurse staffing, medical staffing and delayed transfers of care (DTOC).
- The Group Strategy also identified 16 priority areas to improve quality, which ranged from infection prevention, reducing patient harms and improving the patient experience to treatment times, national clinical audit and safe staffing.
- Divisional leaders prioritised patient safety as a key consideration and reviewed the Patient Safety Scorecard each month during DAG meetings. The dashboard contained key patient safety indicators covering safety thermometer, falls rates, pressure ulcers, infection rates, medication administration, patient safety incidents, complaints, venous thromboembolism screening, cognitive screening and mortality data.
- The trust commissioned a Quality Improvement Plan (QIP) to be compiled following the inspection in March 2016. This plan, dated September 2016, highlighted 28 items for review. All areas included in the QIP were aligned to clinical areas, 14 of which were relevant to the division. These included telemetry, risk register processes, NEWS, records management (including information governance and documentation), safe staffing, medicines management (storage, safety, administration, and reconciliation), NICE guidelines, staff engagement and mandatory training.
- We saw the trust NatSSIPs and LocSSIPS implementation schedule. This detailed some 35 projects, eight were completed, 11 were in the implementation phase and the remainder were planned. All had a designated clinical lead, implementation lead and supporting team. The projects all had commencement and target dates.

Culture within the service

- Staff at all levels spoke enthusiastically about their work, about the quality of care delivered across the division and of the improvements made over the last 12 months.
- Staff described how the organisational and divisional culture was maturing and responding to the last inspection report.

- Staff considered the organisational culture had improved since the last inspection with leaders being more open, honest and transparent about the issues faced. Staff reported positive progress since the report publication, however acknowledged this was work in progress and required time to embed.
- At focus groups prior to the inspection, we heard divisional staff describe a real 'team' culture and resilience on wards. Staff described strength of ward comradery and staff 'pulling together' to get the job done. We observed this on ward visits with staff from a variety of specialisms working together effectively.
- Staff morale was variable, but improving and this did not detract from a determination to ensure patients received the best care possible. Staff had an awareness of the issues affecting performance and morale. Staff acknowledged the work of the managers to address key issues, which were sometimes outside their control and limitations.
- Overall, staff we spoke with told us their immediate line managers and clinical leaders were professional, supportive and helpful. Matron support on AMU was reported to be very good and it was reported she was happy to get involved clinically to support unit when required. Matron support on some of the general divisional wards was variable.
- Junior nursing and medical staff described their senior peers to be supportive, approachable and willing to spend time with them when necessary.
- Staff considered the leadership were more conscious of, and involved in dealing with, issues faced on wards and in clinical areas.
- Staff commented how the organisational culture was all about its people, its team and its 'family'. Some newer members of staff to the division commented on the positivity of this ethos, however added this made the organisation insular at times.

Public engagement

- The division contributed to the Patient and Public Experience Activity Report compiled in 2016. The audit considered patient experience across four domains namely improving access and waiting, building closer relationships, safe, quality and coordinated care and the hospital environment. This included clinicians, therapists and specialist services such as dementia and diabetes. This culminated in some external public listening events.
- The division had taken part in the trust real-time in-patient survey which considered 14 key questions relating to in-patient care such as ward cleanliness, food quality, pain, privacy and dignity, involvement in care, quality of care and quality of staff. Overall, patients commented positively about staff and care received however, there were some variable responses to ward cleanliness and food quality. Ward leaders confirmed real-time findings were considered on each individual ward and discussed by the leadership team.
- Wards displayed information for patients and their families on ways in which they could provide commentary about their experiences in a more confidential setting such as accessing the Patient Advice and Liaison Service (PALS).
- The division had good links with numerous volunteer organisations, charities and national support groups.

Staff engagement

- Staff commented how there had been an increased effort by divisional managers and the leadership team to engage with the staff agenda.
- Staff reported low morale on some wards, which mainly focussed around "staffing numbers", being frequently moved to work in other clinical areas and the potential impact this has on patient care.
- The leadership team implemented a 'Let's do lunch' campaign where they meet with staff informally in the ward environment to discuss issues over lunch. Whilst there has been some staff cynicism to the agenda behind these exercises, the event we attended generated a lot of debate and constructive challenge. We are unclear how information from this event was captured, shared with the wider team and progressed.
- Staff have been involved in feedback surveys outside of the NHS Staff Survey. In October 2016, divisional leaders compiled a staff 'emoji' survey using happy to sad faces to generate interest within staff to provide commentary about 'how was your shift?' Findings from the survey highlighted the strength of the nursing team and the benefits of having a shift leader. Staff commented about frustrations at not having access to a transfer team which affected staffing and workload. As this survey was a small pilot, the division proposed completing this again to gain more in-depth and wider feedback.
- The division had supported cohort staff engagement activities such as Band 7 sessions.

- Divisional leaders had supported staff awards and recognition initiatives such as Pride of Airedale and local patient harm-free accolades. The division had award winners in quality, innovation, patient care and experience, ward of the year and team of the year categories.
- The division also took part in the HR driven 'Lean on Me' initiative to support staff wellbeing at work.

Innovation, improvement and sustainability

- The division provided us with detail of innovative activities and improvement projects over the last 12 months.
- The division was considering a number of cost improvement programmes (CIPs) to improve service quality and sustainability. These included changes to cardiology, rheumatology and ambulatory care pathways.
- In November 2016, the division took part in the Right Care Strategy - Patient Pathways and Flow Programme Rapid Improvement Event. The programme aimed to identify ways to reduce discharge delays, avoid unnecessary hospital admissions and improve the patient experience. As a result of the event, the processes for complex discharges have been refined with improved partnership working with external partners. The division reduced the number of patients with a length of stay over 30 days by refining the pathway and using electronic solutions for referring to the Continuing Health Care Team. The division improved discharge processes internally to aid flow utilising technology to support these processes.
- In December 2016, the division also took part in a rapid improvement event looking at SAFER care bundle improvements to support better flow through the organisation. The project team are considering outputs in more detail and in line with other improvement events. Staff commented positively about this as it brought ward staff, senior clinicians, managers and the leadership team together.
- The division secured funds for a new urgent assessment facility planned for 2018 which will mean a reconfiguration of acute services including CCU, AMU and ambulatory care services. The objective was to ensure prompter initial assessment, reduce waits and provide better patient experience.
- The development of FEP Team, to ensure this cohort of patients get right care in the right place at the earliest opportunity had been progressive. The MDT team have demonstrated admission avoidance, reduced length of stay, less intra-hospital moves, reduction in readmission rates, cost savings and improved patient experience.

Surgery

Safe	Requires improvement
Well-led	Requires improvement
Overall	

Information about the service

The surgical service group provides a range of surgical services for the local population of Yorkshire and Lancashire and surrounding areas.

The trust has eight main operating theatres and a separate theatre called the Dales suite, situated away from main theatres. The trust has five surgical wards covering general surgery, elective orthopaedics, a day surgery unit and trauma and orthopaedics. Overall, the trust had 103 inpatient surgical beds. At the time of the inspection, the number of inpatient beds was 114 due to increased occupancy.

The trust provides elective and non-elective (acute) treatments for different specialities such as breast surgery, general surgery; lower and upper gastrointestinal surgery, trauma and orthopaedics and urology. Visiting specialities included vascular, maxillofacial, ear, nose and throat, oral surgery, ophthalmology and plastics.

From November 2015 to October 2016, there were 18,283 surgical admissions. Day cases admissions accounted for 58.7% (10,727) of all surgical admissions. Emergency admissions accounted for 29.7% (5,427) of admissions and 11.6% (2,129) were elective admission.

During our inspection, we spoke with 42 members of staff including ward clerks, nurses, doctors, domestics, ward leaders, service leads and allied health professionals. We spoke with two patients and one relative. We visited all surgical wards, theatres and the day surgical unit. We reviewed 22 sets of patient records including medical, nursing and medication charts. We observed care and treatment of patients and reviewed a range of performance information about the surgical services group.

The trust was inspected during an announced comprehensive CQC inspection in March 2016. We rated the service as requires improvement for safe and well-led. Effective, caring and responsive were rated as good. Overall, the service was rated as requires improvement.

Summary of findings

We carried out this inspection because, when we inspected the service in March 2016, we rated the service as 'requires improvement' in safe and well-led. We asked the provider to make improvements following that inspection.

Actions the trust were told they must take were:

- Ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- Ensure the safe storage and administrations of medicines including the management of patient group directives.
- Ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.
- Ensure that were the responsibility for surgical patients is transferred to another person, the care of these patients is effectively communicated.
- Ensure that staff complete their mandatory training including safeguarding training.
- Ensure that physiological observations and national early warning scores (NEWS) are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.

At this inspection we rated surgical services as requires improvement because:

- Although there had been improvements, some of the issues raised at the 2016 inspection remained a concern. For example nurse staffing levels, mandatory training rates and the embedding of the five steps for safer surgery including the World Health Organisation (WHO) safety checklist.

Surgery

- The Dales suite was not compliant with some aspects of HBN 26 – facilities for surgical procedure in acute general hospital or guidance from the Department of Health and The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises.
- In some clinical areas, we observed poor compliance with the trusts infection prevention and control policy and there was an inconsistent approach to the storage of single use equipment and the decontamination of laryngoscopes in theatre.
- There was inconsistency in the application of systems, processes and standard operating procedures, including the WHO five steps to safer surgery, to keep people safe, particularly within theatres.
- Records were not always stored securely and there was a risk that patient's confidential information could be accessed.
- There were occasions when actual nurse staffing levels were not in line with planned nurse staffing levels.
- Risks that threatened the delivery of safe and effective care were not always identified promptly and adequate action taken to manage them. For example, the environment in the Dales suite.

However, we also found:

- The service had taken action on some of the issues that related to patient safety in the 2016 inspection. For example, patient's observations were correctly recorded and patients who were at risk of deteriorating were escalated in a timely manner. There were processes in place to ensure that medication was stored securely. Medications that required refrigeration were stored appropriately in fridges.
- Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system. We saw evidence of lessons learnt and changes in practice following incidents.
- The service had clear governance structure and a clear responsibility and accountability framework had been established. Staff were clear about their roles and understood their level of accountability.
- All staff spoke positively about the visibility of the senior management team and felt staff engagement and the culture within the organisation had improved.
- Each ward had an improvement plan which was reviewed regularly by the ward leader, matron and director of nursing. Staff felt these helped drive improvement.

Surgery

Are surgery services safe?

Requires improvement

We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection, we rated safe as requires improvement because:

- The Dales suite was not compliant with some aspects of HBN 26 – facilities for surgical procedure in acute general hospital or guidance from the Department of Health and The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises.
- In some clinical areas, we observed poor compliance with the trusts infection prevention control policy and there was an inconsistent approach to the storage of single use equipment and the decontamination of laryngoscopes in theatre.
- There was inconsistency in the application of systems, processes and standard operating procedures, including the WHO five steps to safer surgery, to keep people safe, particularly within theatres.
- Compliance with mandatory training within surgical services varied against the trust target of 80%. For example, compliance with information governance training amongst nursing staff ranged from 36% to 66%.
- Records were not always stored securely and there was a risk that patient's confidential information could be accessed.
- There were occasions when actual nurse staffing levels were not in line with planned nurse staffing levels.

However:

- Patient's observations were correctly recorded and patients who were at risk of deteriorating were escalated in a timely manner.
- Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system. We saw evidence of lessons learnt and changes in practice following incidents.
- There was a process in place for the checking of electrical equipment and all checks were up to date.

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. There was one never event reported from February 2016 to January 2017.
- The never event was reported in January 2017 and related to a 'wrong site surgery'. At the time of our inspection, the investigation had been investigated and the final report was awaiting executive level approval. However, staff in theatre were aware of the incident and able to describe some initial actions taken. For example, adding an additional check during the safety brief prior to commencing the theatre list.
- Serious incidents are incidents that required further investigation and reporting. The surgical services group reported seven serious incidents from January 2016 to December 2016. The most commonly reported incidents were pressure ulcers that met the serious incident criteria (43%).
- Ward 9 had reported three serious incidents relating to pressure ulcers. The incidents occurred in June and July 2016. This had been identified by the service and due to the close proximity of the incidents; the service reported and investigated the incidents as a cluster to examine if any common themes could be identified.
- A root cause analysis (RCA) is a structured method used to analysis serious incidents. We reviewed the root cause analysis relating to the cluster of pressure ulcers on ward 9. The RCA identified identify lessons learnt, recommendations and included an action plan.
- Staff were able to describe the lessons learnt following the serious incidents on ward 9. Staff said all patients identified as at risk of pressure ulcers were discussed at the daily safety huddle, staff had completed training on the Waterlow score (a tool used to assess the risk of patients developing pressure ulcers) and there was more awareness of patients with plaster casts. Staff now used coloured tape on the cast to identify patients at high risk.
- From February 2016 to January 2017, surgical services reported 1036 incidents to the National Reporting and Learning System (NRLS). Of these, 654 resulted in no harm, 305 resulted in low harm, 14 resulted in moderate harm, and none resulted in severe harm or death.
- The hospital had a serious incident policy which set out the process for the reporting of incidents, near misses

and adverse events. Staff were encouraged to report incidents using the hospitals electronic reporting system. The staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents, including near misses.

- The majority of staff said they received feedback following completion of incidents forms. Staff said learning from incidents were shared through ward meetings, use of communication files and at safety briefs prior to handover. We reviewed ward meetings minutes and saw examples of feedback from RCA investigations and lessons learnt.
- 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 were aware of the duty of candour and spoke about being open and honest with patients and their relatives. Staff were able to give examples of when the duty of candour had been applied, for example, following medication errors. We saw evidence of the duty of candour being implemented in RCA investigations.
- Mortalities were discussed at the surgical audit meeting.

Safety thermometer

- The NHS patient safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- In the reporting period, January 2016 to January 2017, data from the patient safety thermometer showed the service had reported eight pressure ulcers, seven falls with harm and six catheter urinary tract infections.
- The full safety thermometer was not displayed in ward areas. However, we saw the number of fall free days and days since a pressure ulcer were displayed.
- The service submitted data to the NHS safety thermometer. Results showed from October 2016 to March 2017, all wards reported 95% harm free care or above with the exception of ward 9, which score 89% in February 2017.

Cleanliness, infection control and hygiene

- From April 2016, up until the time of our inspection, there were no cases of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) and three cases of hospital acquired Clostridium difficile (C. difficile) across surgical services.
- From February 2016 to February 2017, there were nine incidences of methicillin-sensitive Staphylococcus aureus (MSSA) and 147 cases of E-coli were reported.
- The trust screened surgical patients for MRSA in accordance with national guidance.
- The infection, prevention and control (IPC) team delivered training face to face and via e-learning. Training rates for nursing staff showed all wards were below the trust target of 80%, with the exception of ward 19.
- IPC information was visible on all the wards we visited. Information on hand hygiene compliance, the number of days since the last case of C. difficile and MRSA was displayed.
- The majority of ward areas were visibly clean, however all wards appeared cluttered and there was a lack of available storage.
- Hand sanitiser was available at the entrance to ward areas and in clinical areas. With the exception of ward 19, there was no clear signage to encourage visitors and staff to wash their hands when entering and exiting the ward.
- In some clinical areas, we observed poor compliance with the trusts IPC policy. For example, on ward 14 we observed three members of staff walking around the ward wearing gloves and aprons after delivering patient care. One member of staff went between patients without removing their gloves and apron or washing their hands.
- The service completed monthly hand hygiene audits. From March 2016 to March 2017, the average compliance on ward 9, 13 and 14 was 97%. Ward 18 was 99% compliant and theatres were 98%.
- All staff were compliant with the trusts bare below the elbows policy.
- On ward 9, we saw a patient with an infection being nursed in a side room. There was no clear signage displayed on the door to indicate that the patient had an infection. Therefore, there was a risk people might not use the correct precautions when delivering patient care in the room

- Equipment was identified as being clean using cleaning assurance stickers. The label contained the date the equipment had been cleaned. This provided assurance to patients that reusable equipment was ready for use.
- On the previous inspection, we identified that the elective orthopaedic ward (ward 19) was carpeted. We found that this had been removed and replaced with laminate flooring.
- The trust participated in national surgical site infection surveillance for patients undergoing orthopaedic surgery following a fractured neck of femur. Data we reviewed showed that from April to June 2016, the surgical site infection rate was 0%, which was better than the England average of 1.4%.
- Within theatre, we found a number of single use, laryngoscope blades and forceps not stored in packaging. This was not in line with guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). It was not clear if the equipment was sterile and there was no traceability in the event of a product recall. We raised this with the matron and on our unannounced visit we found laryngoscope blades and forceps still not stored in their packs.
- In theatre, there was an inconsistent approach to the decontamination of reusable laryngoscope handles. This was highlighted at the previous inspection. The service had developed a standard operating procedure; however, not all staff were aware of it.
- Within theatres, we found some equipment had visible stains on the pedals, moving and handling equipment was stored on the floor in theatres, attachments for operating tables had visible defects in the plastic covering, exposing the foam underneath and we observed dust on some anaesthetic machines and airway trolleys.
- On our unannounced inspection, we found two sterile trolleys' set up in theatre with sterile instruments and swabs. Guidelines from the Association for Perioperative Practice (2016) state preparation of sterile trolleys in advance is not recommended.
- Following our previous inspection, staff highlighted that there was insufficient capacity within laminar (specialised ventilation) theatres. We discussed this with the senior management team who stated increasing capacity was part of the services two-year plan and they were exploring options to increase capacity.
- The Dales suite was situated away from main theatre and was used for ophthalmology procedures, children's dental procedures and minor procedure performed under local anaesthetics. The environment was not compliant with guidance from the Department of Health, HBN 26 – facilities for surgical procedure in acute general hospital. During our unannounced inspection, we found three instrument trolleys set up in the scrub area. HBN 26 states that in an operating theatre with a recessed scrub area, it is essential that it is located away from the area containing set-up instrument trolleys in order to prevent water contamination.
- Clinical and domestic waste bags were stored in the corridor used by patients to access theatre.
- The walls had a number of defects and were covered in painted wall paper. HBN 26 recommend that the quality of wall finished in all areas should be of a high standard and wall coverings should be durable.
- The ceiling tiles in theatre had visible stains and gaps. HBN 26 states that modular ceilings are not acceptable in theatres.
- A box containing used equipment was stored on the floor in the same area where patients underwent local anaesthetic.
- Inside the domestic room, there was a hole in the ceiling and water stains on the tiles; staff reported this following a leak. We found a sterile trolley was set up in the room. Staff said this area was used to clean equipment prior to it being returned to the sterile services department.
- We raised our concerns with the matron during the unannounced inspection. The Dales suite was not on the services risk register. However, following our unannounced inspection the concerns were added to the services risk register and a risk assessment was completed.
- We reviewed the risk assessment and found the service had sought assurance about the suitability of the environment from a consultant microbiologist and matron for infection prevention. Actions taken included, identifying an area for the storage of waste, moving the cleaning of used equipment from the domestic room and providing a separate room for staff to eat their lunch away from the clinical area. The trust was in the process of reviewing the provision of surgical activity and had plans to move activity carried out in the Dales suite into a new procedure room which would have specialist ventilation. The timescale for this project was anticipated to be between one to two years.

Surgery

Environment and equipment

- We checked 21 pieces of equipment including observation machines, suction machines, scales and single point of testing equipment. All equipment had visible evidence of electrical testing indicating safety checks and when it was next due for servicing.
- In 2016, we said the trust must ensure that resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines.
- We checked the adult resuscitation trolleys in all the clinical areas and found daily and weekly checks were not consistently performed as per trust policy and in line with best practice. On ward 13, we found gaps in the daily checking from the 27 February to the 5 March. On ward 14, we noted three days in March when daily checks had not been completed and on ward 19 daily checks were not completed from the 07 March to the 09 March.
- At the previous inspection we were not assured that daily safety checks of anaesthetic machines were been completed in line with recommendations from AAGBI. Following our inspection, the book used to record the safety checks had been removed and safety checks were now recorded in individual patients anaesthetic records.
- Ward 9 was included in the trust patient-led assessments of the care environment audit (PLACE). The ward scored 87.2% for the condition, appearance and maintenance. This was below the national average of 94%.
- In some clinical areas, we noted issues with the estate. For example, in the corridors in theatre we saw damage to the plaster and holes in the walls. This was not recorded on the services risk register. We raised this with the matron and this was placed on the services risk register. On ward 13, in the sluice, we noted a significant crack in the wall. Staff said this had been reported in November 2016.
- In theatre, we observed some pieces of equipment were rusty and extensive rust was visible on some storage trolleys. Staff said equipment was in the process of being replaced.
- Theatre staff we spoke with said there were adequate stocks of equipment and we saw evidence of stock rotation to ensure equipment was used prior to expiry date. Staff said that they had access to all surgical instruments they required.
- Equipment for bariatric patients was available and staff we spoke with were aware of how to access this.
- The Dales suite was situated away from main theatre and was used for ophthalmology procedures, children's dental procedures and minor procedure performed under local anaesthetics. The environment was not complaint with aspects of HBN 26 – facilities for surgical procedure in acute general hospital or guidance from the Department of Health, The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises.
- The Dales suite was used for both local and general anaesthetic. Guidance from the Department of Health, The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises states a degree of specialist ventilation is required if anaesthetic gases are used. The Dales suite did not have a specialised ventilation system.
- Within the Dales Suite an area designated for handwashing was also used as a staff kitchen. A number of cups, biscuits, a kettle and microwave were on the work surface. This area was adjacent to where patients underwent local anaesthetic and were recovered.

Medicines

- In 2016, we said the trust must ensure the safe storage and administrations of medicines.
- We checked the storage of medications, including intravenous fluids, on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Accurate records were maintained in accordance with the trust policy, including regular balance checks .
- On our unannounced inspection, in two separate anaesthetic rooms, we found medication drawn up and left unattended. There was a risk that the medication could be used inappropriately.
- We reviewed 17 prescription charts and found allergies were clearly documented and patients received their medicines in a timely way and as prescribed.

- Ward 20 used a paper based prescription pro-forma and did not prescribe patients regular medicines upon arrival at the ward. Patients self-administered their own medicines during their day case surgery; these were not recorded and no assessment was made of each patient's suitability to self-administer in line with the trust's policy.
- The pharmacy provided a medicines reconciliation and discharge service on ward 9. During our visit, we identified four patients with discrepancies in prescribing that had been identified, but not actioned by medical staff or followed up a pharmacist. A drug interaction had been identified for one patient, however, this had not been followed up and the patient had continued to receive 18 doses of the two medicines between 7 March 2017 and 30 March 2017. We brought this to the attention of staff during the inspection.
- Following our concerns, the pharmacist reviewed all the prescriptions on ward 9 and the trust reviewed and revised the pharmacy standing operating procedures (SOPs) relating to medicine reconciliation and prescription reviews. Changes were communicated to pharmacy staff verbally and via email.

Records

- We reviewed 22 sets of records and found they were accurately completed and legible. All entries were signed and dated, and the name nurse and clinician was clearly stated.
- The majority of nursing records were up to date and appropriate risk assessments and care plans were completed. We saw evidence of a range of risk assessments including; falls, pressure ulcers, moving and handling, infection risks and nutrition and hydration.
- Staff used a combination of electronic and paper records. In the majority of clinical areas patient records were stored in unlocked trolleys behind the nurse's station.
- Staff on ward 13 and 14, placed blood test request forms in wooden boxes on the outside of the nurse's station. We saw each blood test request form contained the patient's full name and address and included an 'inpatient overview' sheet with patient names and NHS numbers. This information could be easily viewed and accessed by anyone walking along the corridor.
- On ward 20, patient medical records were not stored securely. They were stored outside of patient bays on tables and in file holders. Therefore, confidential medical information could be easily accessed. We raised this with the matron. A recent risk assessment had not been completed.
- Documentation was audited as part of the services monthly key performance indicators. Ward leaders completed the audit electronically. Results were submitted and shared with the matrons and service leads. We reviewed audit results and found generally good compliance. Any areas of non- compliance were shared with staff and incorporated into the ward development plan.
- Results from the surgical group patient safety scorecard demonstrated 89.5% compliance with VTE risk assessments in January 2017. This was below the trust target of 95%.
- The percentage of nursing staff that had completed information governance training ranged from 36% to 87%.

Safeguarding

- The trust's safeguarding policy provided a framework for all staff when identifying, responding to and reporting any aspects of safeguarding.
- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Staff we spoke to knew how to escalate safeguarding concerns. Staff were clear about what was seen as a safeguarding concern and their role in reporting and escalating a safeguarding concern. Staff were aware of the safeguarding lead for the trust and understood the process for making a safeguarding referral.
- Staff shared examples of safeguarding referrals made. On ward 9, we saw an example of a patient who had been appropriately referred to the safeguarding team.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by annual safeguarding training. Training data provided by the trust showed compliance rates for medical staff ranged from, 90% to 100% for safeguarding vulnerable adult's level one training and 90% to 100% for safeguarding children level two training. Compliance amongst nursing staff averaged 90% for safeguarding vulnerable adult's level one training and averaged 86% for safeguarding children level two training. This was against the trust target of 80%.

- The trust did not provide any level three training data for nursing in the surgical directorate.

Mandatory training

- The trusts mandatory training consisted of nine topics and included fire safety, infection and prevention control, moving and handling, information governance, conflict resolution and resuscitation.
- In 2016, we said that the trust must ensure that staff complete their mandatory training including safeguarding training. We found overall that 61%of surgery nursing staff had completed mandatory training, 81% of medical staff had completed the training and within theatre, overall 62% of staff had received mandatory training.
- We found overall compliance within the surgical services group was varied against the trust target level of 80%. We reviewed training data provided by the trust and found medical staff were compliant in eight of the nine modules; information governance had achieved on average a 76% compliance rate. However, within orthopaedics only 45% of staff had completed the training.
- Nursing staff were compliant with five of the nine modules. Compliance with information governance ranged from 36% to 66%, compliance with conflict resolution ranged from 42% to 84%, compliance with equality and diversity ranged from 52% to 100%, fire safety ranged from 68% to 91%, infection and prevention control ranged from 63% to 91% and manual handling compliance ranged from 36% to 68%.
- Staff said they could access trust mandatory training either via an electronic learning system or could attend face to face training. Staff said it was challenging completing mandatory training due to staffing levels.
- All staff could access their mandatory training record and received alerts to indicate when training was due. Ward leaders could monitor mandatory training compliance.

Assessing and responding to patient risk

- The trust used the national early warning score (NEWS) to assess the health and wellbeing of patients. This assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- In 2016, we said the trust must ensure that physiological observations and NEWS were calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust audited NEWS as part of their monthly nursing key performance indicators. Results from the audit showed good compliance. On average, from January 2016 to January 2017, all surgical wards were above 96% compliant.
- We reviewed 18 sets of observation charts across the surgical wards and found NEWS scores were correctly calculated. With the exception of one, all patients who required escalation were escalated as per trust policy and in a timely manner. We saw documented evidence of appropriate action taken.
- Staff were aware of escalation process and were able to describe how they would escalate a deteriorating patient.
- In February 2017, the trust audited compliance against the National Institute for Health and Care Excellence (NICE), clinical guidelines for acutely ill patients in hospital. The audit reviewed 20 sets of patient records on ward 9 and ward 13 and seven sets of records on ward 19. The audit found 96% of records had a clear documented plan. However, 71% of records did not specify which physiological observations should be recorded and 85% did not specify the frequency of observations. Recommendations from the audit were being implemented.
- The acute care team was available 24 hours a day, seven days a week to support staff with patients who were at risk of deteriorating. Staff said the team were very responsive and patients could be escalated to level 3 beds if required.
- The World Health Organization (WHO) surgical safety checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. In the previous inspection, we said that the trust must ensure the five steps for safer surgery including the WHO safety checklist was consistently applied and practice audited.
- The service audited the completion of the WHO checklist monthly as part of theatre's key performance indicators. We reviewed audit results from August 2016 to February 2017. Results from the audit showed 100% compliance with all sections of the checklist with the exception of the 'sign out' in August 2016, November 2016 and January 2017. Actions taken included plans to

display the audit results in departments, improving engagement and ownership of the 'sign out' and escalation of staff who consistently demonstrate non-compliance.

- During both the inspection and unannounced inspection, we reviewed six sets of surgical notes containing WHO checklists and found in two sets, the checklist was incomplete. We observed five patient operations and in the majority of occasions the checklist was completed; however, from our observations it was apparent that this was not a consistent process and not always in line with best practice. For example, not all elements of the checklist were always verbalised, the safety brief was not repeated for staff that were new to the team, the silent focus was not consistently observed and in one case a member of staff left before the sign out was completed.
- The service had modified the checklist to set out the minimum team required. It also stated that "where possible the whole team should take part in the sign out". This was not in line with best practice.
- Staff used appropriate risk assessments and care plans. We saw evidence of a range of risk assessments including falls, pressure ulcers, moving and handling, infection risks and nutrition and hydration.
- We reviewed five sets of records on ward 13 and found, in three sets of records, when the patient was identified as high fall risk, actions taken to reduce the risk of falls were not documented and appropriate care plans were not in place. It was also not clear from the documentation what actions should be taken by staff if a patient was identified as high risk.
- Patients who were identified as high risk of falls had an individualised falls prevention care plan. We reviewed the care plan and found it was not based on national guidance. The service did not have a policy for enhanced supervision. The trust provided us with an action plan for implementing an enhanced supervision project which included developing guidelines.
- Results from the surgical group patient safety scorecard demonstrated 89.5% compliance with venous thrombosis (VTE) risk assessments in January 2017. This was below the trust target of 95%.
- Patient records did not contain a sepsis screening tool and not all ward staff were aware of the trusts sepsis pathway.
- In 2016, we said the trust must ensure that where the responsibility for surgical patients is transferred to another person, the care of these patients is effectively communicated. We observed a surgical morning handover and staff now kept a logbook to record attendance. An audit of surgical and urology handover in November 2016, showed an improvement from the audit in 2015. However, the audit identified the consultant was not present on eight occasions, documentation of the handover process was poor and the evening urology handover only occurred 72% of the time.
- During our inspection in 2016, the elective orthopaedic ward had been recognised as having an increasing number of falls. The ward had implemented strategies to reduce the risk of falls and received an award for achieving over 60 fall free days.

Nursing staffing

- The trust used the safer nurse care tool, Royal College of Nurse staffing guidelines and The National Institute for Health and Care Excellence (NICE) guidelines to assess nurse staffing levels. The trust reviewed nurse staffing levels every six months.
- In 2016, we said the trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- At the time of the inspection, surgical wards, and departments including theatres had 16.8 whole time equivalent (WTE) vacancies. This was similar to the number of vacancies seen in 2016 (20.8 WTE).
- The trust was actively recruiting and had taken some actions to try and address the recruitment challenge. For example, the trust had 26 registered nurses working as band 3 healthcare assistant whilst they awaited their professional identification number from the Nursing and Midwifery Council. Most of these nurses were international recruits who were going through the process of gaining the international English language test requirements. The trust had also recruited apprentice healthcare support workers, introduced discharge coordinators, provided additional administration support to the wards and had recruited band 4, nurse associate roles.
- The trust had carried out a nurse establishment review; this was ongoing and reviewed every six months to ensure acuity levels were met with the right staffing levels.

- The surgical wards displayed planned and actual nurse staffing levels for each shift. The trust-defined qualified nurse to patient ratio was 1:8 in the day and 1:15 at night on surgical wards and on the surgical assessment unit, 1:6 day and night. Ward 9 planned qualified nurse to patient ratio was 1:6 in the day. Ward 19 was all single rooms and the aspirational ratio was two registered nurses to 11 patients.
- Prior to the inspection, from September 2016 to December 2016, surgical wards achieved on average between 72.9% and 108% fill rates for qualified nurses (day shifts) and between 66.7% and 114.8% (night shifts).
- We reviewed daily staffing reports for registered nurses and healthcare assistants and found there were a number of occasions where actual staffing levels did not meet planned. For example, from the 30 January 2017 to the 5 February 2017, across surgical services, out of 105 shifts, 34 shifts had below the planned registered nurse staffing levels. We reviewed data from the 11 March 2017 to the 17 March 2017 and found that out of 105 shifts, 45 shifts had below the planned nurse staffing levels.
- When registered nurse staffing levels did not meet planned levels, this was escalated to the senior sister and matron. The trust had an escalation process in place to address staffing shortfalls.
- The service used bank and agency staff to improve staffing levels. From February 2016 to January 2017, the trust reported a bank and agency use of 1.2% in surgery.
- Daily safety brief reviews took place each day across the hospital. The purpose of this meeting was to ensure at least minimum safe staffing levels in all areas. Senior staff attended safety briefings. Staff were often moved from their substantive area to ensure minimum staffing levels in all areas.
- Staff reported frustrations at staff being frequently moved to support other areas. Staff said on occasions some wards were left with only one registered nurse and healthcare support workers.
- We reviewed incident data and found 47 incidents relating to nurse staffing had been reported from February 2016 to January 2017. All of the incidents were categorised as no or low harm. However, we saw examples of when staffing levels had impacted on patient care. For example, on the 6 January 2017 an incident was reported in which staff were unable to respond to buzzers in a timely manner, medications were late, staff were unable to take breaks and they were unable to reposition patients. On the 11 December 2016, it was reported that the ward had only one registered nurse to 21 patients which had led to delays in providing care and treatment.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that each patient's clinical condition was discussed and any risks were identified. The handover included a safety brief which discussed any lessons learnt from complaints or incidents.

Surgical staffing

- We reviewed the medical staffing rota and spoke to consultant, middle grade and junior doctors. Medical staff were available 24 hours a day. Junior doctors were available on-site 24 hours and day. Middle grade and consultants were available on-site approximately 12 hours a day and available on call 24 hours a day.
- Medical skill mix was similar to the England average for consultants and junior doctors. From 1 October 2016 to 31 October 2016, the proportion of consultant staff working at the trust was about the same as the England average. The proportion of junior (foundation year 1-2) staff reported to be working at the trust was higher than the England average.
- All junior doctors said senior staff were accessible at all times and they felt supported in their role. Staff said they had access to training however; this was sometimes impacted on due to their workload.
- Junior doctors we spoke with said they were aware of some gaps in medical staffing rotas; however, these were covered by locum medical staff. Staff said if the shifts were not covered, this had an impact on the workload of other medical staff.
- At the time of our inspection, data provided by the trust showed from March 2016 to January 2017, the trust reported a vacancy rate of 16% in surgery. This equated to 11.18 whole time equivalent. From the data provided, it was not clear if these where consultant, middle grade or junior posts.
- The service used locum staff to improve staffing levels. We reviewed the use of locum staff from February 2016 to January 2017 and on average, the locum usage reported in surgery was 5.4%. This had decreased from our previous inspection where the average locum usage was 15%.

Surgery

- Within surgery, medical handovers took place twice a day. We observed a morning handover from the night team and saw new patients were discussed and investigations reviewed. Staff now kept a logbook to record attendance. An audit of surgical and urology handover in November 2016 showed an improvement from the audit in 2015. However, the audit identified the consultant was not present on eight occasions, documentation of the handover process was poor and the evening urology handover only occurred 72% of the time.

Major incident awareness and training

- The surgical services had appropriate policies with regard to major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke with knew how to access the major incident policy for guidance on the trust intranet.
- The trust carried out critical incident simulation exercise in various clinical areas throughout the hospital. Following each simulation exercise, all staff involved received a written report on how the scenario was performed and a monthly newsletter was sent to all staff to share any lessons learnt. As of September 2016, the team had carried out 40 separate exercises in all areas of the hospital in which 227 members of staff had attended.

Are surgery services well-led?

Requires improvement

We carried out this inspection because, when we inspected the service in March 2016, we rated well-led as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection, we rated well-led as requires improvement because:

- We were not assured that the service identified appropriate risks or documented plans to mitigate these issues. This was identified in our 2016 inspection. For example, environmental factors seen in the Dales suite and theatres were not contained in the service risk register or raised in interviews with senior staff.
- Due to staffing constraints, ward leaders were needed to provide clinical care on the ward. Although some mitigating action had been put in place, staff told us that this impacted on their capacity to complete management tasks in working hours. This was also identified as an issue in our 2016 inspection.
- Monthly governance meetings were in place however, attendance at these meetings had been poor. This was also identified as an issue in our 2016 inspection. Ward meeting did not always occur at regular intervals, as staff understood they should.

However;

- All staff spoke positively about the visibility of the senior management team and felt staff engagement and the culture within the organisation had improved.
- The service had clear governance structure and a clear responsibility and accountability framework had been established. Staff were clear about their roles and understood their level of accountability.
- Each ward had an improvement plan which was reviewed regularly by the ward leader, matron and director of nursing. Staff felt these helped drive improvement.

Leadership of service

- Surgical services had a clear management structure. The services was split into three sub-services, each was led by a patient service manager and matron. The deputy director of operations, head of nursing and clinical directors formed a triumvirate.
- In the 2016 inspection, it was noted that the senior management team was new and that it had not time to embed and implement changes. During this inspection, we noted the management team had been stable and were more effective in their roles. The team had addressed some of the issues raised in the previous inspection.
- The management team had been able to implement some changes and held a quality improvement event.
- None of the ward leaders were supernumerary. Ward leaders were needed to provide clinical care on the ward and did not have capacity to take management time required for them to focus on management and administrative issues.
- Staff we spoke with said some ward leaders came into work in their own time to catch up on management tasks.

- There had been some instability in the leadership on ward 14. At the time of our inspection the ward leader post was out to advert. The service had identified the need to provide senior leadership and had place a temporary band 7 on the ward to support the team.
- At the previous inspection, staff did not always feel that if they raised concerns they would be listened to. During our inspection staff spoke positively about the support they received from the matrons and senior leadership team. Staff said they were visible and visited the wards regularly. Staff felt confident to raise concerns and that they would be listened to.
- The matrons had changed their working hours and now worked longer days. This enabled them to be more visible and accessible to support staff on an evening.
- The trust offered a range of management and leadership development programmes. For example, one ward leader had completed an external leadership course.
- Ward 9 had won the ward of the year and leader of the year in the 2016 Trust awards.
- Staff felt there had been an improvement in the visibility of the executive team since our previous inspection. Staff said the team would do regular walk rounds of clinical area. All staff spoke positively about the interim director of nursing and felt they had worked hard to drive improvement, change the culture and manage staff engagement.
- Surgical services had introduced 'listening at lunch events' in which members of the senior management team visited a different clinical area weekly and spent time speaking to staff. Staff felt this had helped improve communication within the service.
- Due to staffing constraints, ward leaders were needed to provide clinical care on the ward. This was also identified in our 2016 inspection and impacted on their capacity to complete management tasks. However, the Trust recognised this and had routes of escalation and review to provide support to Ward leaders. This was captured on the Risk Register and monitored throughout the organisation.

Vision and strategy for this service

- The trust had a shared vision of "the right care at the right time for the right patient". Staff we spoke with were aware of the overall trust's vision statement.
- Surgical services had developed a two year annual plan for 2017/2019 that had been reviewed and signed off by the trust board. The proposed service plan was aligned with financial impact, quality impact and productivity impact. The services plan included plans to develop services, staffing and seek cost improvements. For example, developing the orthopaedic service, consultant recruitment and developing a urology investigation unit.
- Staff we spoke with were not aware of the surgical services strategy, or their role within it.
- A programme charter was available for surgical services; its aim was to develop a patient centred quality, safety and efficiency programme.
- Ward 9 had a mission statement to provide "compassionate, quality care over a 24 hour period, focusing on the unique needs of patients & their families".

Governance, risk management and quality measurement

- The surgical directorate was one of three care groups within the trust. The service had clear governance structure in place and the senior leadership team had been stable since our previous inspection.
- A range of governance meetings took place within the service. This included monthly quality and safety meetings, surgical group management meetings, perioperative group meetings and audit meetings.
- A clear responsibility and accountability framework had been established and staff at different levels were clear about their roles and understood their level of accountability and responsibility.
- The service carried out monthly audits of nursing key performance indicators (KPI'S). These were agreed standards of good nursing practice. The WHO checklist was incorporated within the theatre KPI's. The results of the audits were discussed at the nursing leadership group meeting.
- Ward meetings were used to disseminate information to staff. Staff said ward meetings should be held every two months however, due to clinical pressures they were not consistently happening in some areas. For example, meeting minutes for ward 13 showed they had a ward meeting in October 2016 and then another in March 2017. However, staff felt this had improved recently.
- The service held monthly quality and safety governance meetings. In 2016, we noted these meetings were not well attended. We reviewed meeting minutes and saw a standardised agenda which included discussions

around performance targets, incidents, safeguarding incidents, complaints, RCA investigations and the risk register. We noted attendance remained poor. In November 2016, eight of 19 representatives attended. In December 2016, five of 19 representatives attended. In January 2017, 10 of nineteen representatives attended. In this period, we saw that only one meeting was attended by the matron and no meetings were attended by senior staff from wards 9, 14 and 19.

- We reviewed the services risk register and found it reflected some of the current risk relevant to operations. The register documented control measures, actions taken, review dates and any action requires with a named owner. Any risk scoring nine or above was added to the corporate risk register.
- During our 2016 inspection we identified some risks that were not on the services risk register. This remained the case during this inspection, for example, the environmental risks identified in the Dales suite. The Dales suite was not identified as a risk during discussions with the senior management team. Concerns raised about the theatre environment were also not on the risk register. When discussed with the senior management team, they said equipment had recently being moved to expose the damage, but accepted it should have been added to the risk register. It was subsequently added as a risk to the risk register .
- The service had strengthened some of their governance processes and had introduced patient safety scorecards. The scorecard provided data on a range of patient safety indicators including the number of falls, pressure ulcers, hospital acquired infections, medication errors, patient safety incidents, complaints, WHO checklist, VTE screening, cognitive screening and crude mortality.

Culture within the service

- At our previous inspection we found that morale within surgical services was variable. The trust recognised the pressure staff had been under due to an increase in demand on the services and staffing challenges. Although staff were enthusiastic about their work, staff morale remained variable and staffing moves was having a negative impact.
- Staff described an improvement in the culture since our previous inspection. Staff spoke positively about the support from the matrons and the senior leadership team and said they were more visible in clinical areas.
- The senior management team said they were proud of the staff working within the directorate. Staff said they had received biscuits and cakes from the leadership team and this made them feel appreciated.
- Staff described the senior leadership team as having an 'open door policy'. All staff felt able to confidently raise concerns and felt that they would be listened to and appropriate action taken.
- Most staff described good teamwork and spoke about their colleagues in a positive manner. Staff were proud of the teams they worked in and the patient feedback they had received.
- The trust had appointed a 'freedom to speak up guardian' whose role was to actively encourage and enable staff to speak up safely.

Public engagement

- Surgical wards and departments participated in the NHS Friends and family test (FFT). Data from January 2017 showed that the percentage of patients who would recommend the service ranged from 94% to 100%.
- We saw wards displayed 'you said, we did' that gave examples of changes made by the service in response to patient feedback.
- Ward 19 displayed a number of thank you cards received from patients and their relatives.
- The service completed 'real-time' inpatient surveys to gather feedback from patients.
- Surgical services were piloting the use of a patient diary which allowed patients to record and reflect on their experiences of coming into hospital for a surgical appointment or procedure. The information was to be used to develop and improve services along the entire surgical pathway.

Staff engagement

- At our previous inspection, we said the trust must improve engagement with staff and respond appropriately to concerns raised by staff. The service had focused on improving staff engagement.
- The management team held a quality improvement event; this gave staff the opportunity to work with the improvement team and contribute to service improvement ideas. Staff reported changes had been made following the event.

Surgery

- Staff described the senior leadership team as having an 'open door policy'. All staff felt able to confidently raise concerns and felt that they would be listened to and appropriate action taken.
- Surgical services had introduced 'listening at lunch events' in which members of the senior management team would visit a different clinical area weekly and spend time speaking to staff.
- All wards had a ward development plan. Ward leaders were involved in creating the plan with support from the matron, lead for patient safety and quality and the director of nursing. We reviewed the development plans for all the surgical wards and saw they had timescales, a responsible person and were updated. Examples of improved outcomes included, to reduce avoidable grade three and grade four pressure ulcers.

Innovation, improvement and sustainability

- The service had introduced a revised pre-operative pathway for maxillofacial patients that enabled pre-assessment to take place on the day of their surgery. The service said that this was due to be rolled out to all surgical specialties by June 2017.
- Theatres had introduced portable electronic music players for patients undergoing regional anaesthetic.
- Surgical wards had introduced discharge liaison officers to help facilitate patient discharge.
- The elective orthopaedic was had received a diamond award for achieving over 60 days fall free.
- The service had implemented an electronic acute theatre booking system.
- The trust had introduced advanced practitioners in orthopaedics.

Critical care

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

Information about the service

Airedale Hospital NHS Foundation trust provides critical care services at Airedale General Hospital (AGH). The surgery group manages the service.

There is one critical care unit (CCU) at AGH. The unit is a combined level three (patients who require advanced respiratory support or a minimum of two organ support), level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and coronary care facility. It is staffed to care for a maximum of three level three patients, four level two patients and four coronary care patients.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April and 30 September 2016 there were 265 admissions with an average age of 64 years. Seventy percent of patients were non-surgical, 16% planned surgical and 14% emergency or unplanned surgical. The average (mean) length of stay on CCU was two days.

The acute care team are a team of nurses and senior healthcare support workers who have advanced practice skills. They 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 team is available 24 hours a day, seven days a week.

The critical care service is part of the West Yorkshire Critical Care Network.

In March 2016, CQC carried out an announced comprehensive inspection. We rated safe as inadequate, effective, responsive and well led as requires improvement and caring as good. The service was rated requires improvement overall. Following analysis of a serious incident that occurred in April 2016 and other evidence, CQC undertook a further two inspections, both were unannounced, in May and September 2016. The focus of the two unannounced inspections was staffing levels, training and competency of staff, equipment checks and patient care. We did not re-rate the service following these inspections.

During this inspection we visited CCU. We spoke with three patients, one relative and 18 members of staff. We observed staff delivering care, looked at three patient records, three electronic prescription charts and observed a nursing handover. 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.

Critical care

Summary of findings

We carried out this inspection because, when we inspected the service in March 2016, we rated the service as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection we rated critical care as requires improvement because:

- Although there had been improvements, some of the issues raised at the 2016 inspection remained a concern. For example, the lack of a long term strategy, limited evidence available to show that the service had improved the arrangements for the management of risk, the unit's bed days of care post eight hour delay rate was worse than similar units and at the time of the inspection there was no follow up or support to critical care patients following discharge from hospital.
- The leadership team appeared to have a reactive approach to risk assessment and risk management. Some of the unit's risk assessments had been written between 2009 and 2013. There was no evidence that senior staff had reviewed the risk assessments since these dates.
- The arrangements for coronary care beds for level one and zero dependency patients within the same location as critical care patients of level two and three dependency was not in line with the national service specification. The trust had approved a business case for relocation of these beds; however, the senior management team were unable to confirm the date for the implementation of this.
- Staff knew the future of the unit was for coronary care to move to another ward, but they were unable to tell us of a longer term vision or how critical care linked in to the trust's strategy.
- The rehabilitation after critical illness service was limited. At the time of the inspection there was no follow up or support to patients following discharge from hospital. This was not in line with Guidelines for the Provision of Intensive Care Standards 2015 (GPICS) or the National Institute of Health and Care Excellence (NICE) CG83 rehabilitation after critical illness.
- The service did not have access to patient and relative support groups.
- The service had not undertaken patient or relative surveys or any public engagement in service planning.
- Staff we spoke with had a limited understanding of the deprivation of liberty safeguards (DoLs).
- The service was still working towards some of the GPICS standards. For example, the service did not hold critical care specific morbidity and mortality meetings and out of hours medical staffing was not in line with GPICS standards.

However,

- The service had taken action on many of the issues that related to safe and effective patient care that were raised in the 2016 inspection. For example, nurse staffing levels were now in line with GPICS and the consultant work pattern had changed to provide continuity of care. The unit now had a dedicated clinical educator and the service held records of staff's 'self-assessment competency' of equipment and records of who had received training for specialist equipment.
- There had been a significant change to the leadership team since our 2016 inspections. All staff were positive about the team and morale on the unit had improved significantly. Staff engagement had also improved.
- Systems and processes in incident reporting, infection control, medicines management, patient records and the monitoring, assessing and responding to deteriorating patients were reliable and appropriate.
- Staff were supported to maintain and develop their professional skills. Mandatory training and safeguarding training rates were better than the trust target.
- Care and treatment was planned and delivered in line with current evidence based guidance and patient outcomes were in line with similar units.
- We observed patient centred multidisciplinary team working. Staff took account of, and were able to meet people's individual needs. All of the feedback from patients and relatives was positive about the way staff treated them.

Critical care

Are critical care services safe?

Good

We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'inadequate'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'good' for safe because:

- The service had taken action on the issues raised in the 2016 inspection. For example, nurse staffing levels were now in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS), there was a daily multidisciplinary handover and the consultant work pattern had changed to provide continuity of care.
- The trust had introduced additional cardiac monitors on the critical care unit (CCU) and, introduced a new standard operating procedure for improving the process for the monitoring of telemetry patients on CCU.
- The service showed a good track record in safety. There had been no never events, one serious incident and the incidents reported had mainly resulted in low or no harm. Staff understood their responsibilities to raise concerns and report incidents. Staff told us they now received feedback from incidents.
- Systems and processes in infection control, medicines management, patient records and the monitoring, assessing and responding to risk were reliable and appropriate.
- Mandatory training and safeguarding training rates were better than the trust target.

However,

- The service did not hold critical care specific morbidity and mortality meetings. Medical staff we spoke with told us there was no feedback about morbidity and mortality to the multidisciplinary team. This was not in line with GPICS recommendations.
- Out of hours medical staffing was not in line with GPICS standards; however, at the time of the inspection the trust was actively recruiting staff grade doctors to achieve the standard of resident staffing required for a critical care unit.

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. The service did not report any never events between January and December 2016.
- The service reported one serious incident between January and December 2016. This occurred in April 2016 and on analysis of this and other evidence, CQC undertook two unannounced focussed inspections in May and September 2016. The focus of the inspections following the serious incident were staffing levels, training and competency of staff, equipment checks and patient care.
- The service reported 194 incidents between February 2016 and January 2017. Of the incidents reported, 76% were classed as no harm and 23% as low harm. Frequently reported incidents were infrastructure (including staffing, facilities and environment), implementation of care and ongoing monitoring and review and medication incidents.
- At our 2016 inspection, we were concerned that 83% of incidents were reported over the recommended 60 day time period. Information from the National Reporting and Learning System (NRLS) showed that this had improved and, between January and December 2016, 30% of incidents were reported over the recommended 60 day period.
- All staff we spoke with understood what to report as an incident and how to report it using the electronic system. They gave us examples of incidents that staff reported on the unit; these matched the themes we saw on the incident report.
- Staff told us they received feedback from incidents that had been reported. Senior staff shared information from incidents at handover which included a safety brief, at staff meetings and in the communication folders in the staff room.
- We observed a safety brief as part of the handover. The nurse in charge discussed falls, pressure ulcers and equipment topics.
- Senior staff had completed training to investigate incidents and accessed support from managers and other clinicians as needed.
- 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 with demonstrated an awareness of the duty of candour and the importance of being open and honest when delivering care.
- The trust included the process for duty of candour in the being open policy.
- The service did not hold critical care specific morbidity and mortality meetings. Medical staff we spoke with told us there was no feedback about morbidity and mortality to the multidisciplinary team. This was not in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) recommendations.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- The unit displayed safety thermometer information as part of the patient safety scorecard. This was visible to staff and visitors.
- Data for the unit from January 2016 to January 2017, showed the service reported six new pressure ulcers, no falls with harm and no new CUTI. This meant that on average 94% of patients in critical care received harm free care on the day the data was collected.
- The unit received an award in February 2017 for achieving 80 fall free days.
- The trust used a patient safety scorecard to collect performance information for each ward. The unit displayed the critical care patient safety scorecard for staff and visitors to see. It included metrics such as patient safety incidents (on average staff reported 20 incidents a month), medication incidents (on average three medication incidents occurred a month, none resulted in patient harm), infection control incidents (no incidents had occurred), night time discharges (on average eight patients were discharged at night time a month) and complaints (none had been made).

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed to staff and visitors on the unit.
- All areas on the unit were visibly clean and tidy.
- All the equipment we observed was visibly clean and labelled with the date it had been cleaned.
- We observed staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- One hundred percent of staff in the service had completed infection prevention level one training and 87% of staff had completed infection prevention level two training. This was better than the trust target of 80%.
- There had been no incidences of methicillin resistant Staphylococcus aureus infection (MRSA) or Clostridium difficile in critical care between January 2016 and January 2017.
- Intensive Care National Audit and Research Centre (ICNARC) data showed the unit had no unit acquired infections in blood per 1000 patient bed days between 1 April and 30 September 2016. This was in line with similar units.
- Information provided by the trust on the patient safety scorecard showed there had been no cases of ventilator associated pneumonia between September 2016 and January 2017.
- Senior staff completed monthly audits on compliance with hand hygiene. Information provided by the trust showed the unit achieved 100% compliance for 10 months between January 2016 and January 2017. The unit did not submit the audits for three of the months and compliance was 88% in December 2016.

Environment and equipment

- The unit was secure; access was by an intercom with a security camera.
- The unit provided mixed sex accommodation for critically ill patients in accordance with the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- Staff checked the emergency equipment daily. The records for this were up to date and complete. One piece of emergency equipment was not maintained as sterile; we raised this with the nurse in charge who addressed this immediately.
- The unit had a difficult intubation trolley and emergency equipment was available at every bed space.
- Disposable items of equipment were in date and stored appropriately.
- All electrical equipment we observed was clean and had been safety tested.

- The unit kept up to date equipment maintenance records.
- At our unannounced focussed inspections in May and September 2016, we raised concerns about the processes of setting up and checking of equipment on the unit. At this inspection we saw that high risk medical equipment was labelled and the service had identified super users of equipment who were a resource for staff on the unit. The service had introduced standard operating procedures to support staff in the set-up of high risk medical equipment and we observed evidence of a two person check of equipment at shift handover that was recorded on the observation chart.
- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- We reviewed three electronic prescriptions. Staff administered patients' own medications when they were available. All three prescriptions were completed in line with trust and national guidance.
- We saw evidence in the records that staff had reviewed the use of medication such as sedation and antibiotics regularly.

Records

- Records were stored securely.
- Staff completed a critical care five day care plan that met the National Institute for Health and Care Excellence (NICE) CG50 guidance (a tool for recognising and responding to deterioration in acute ill adults in hospitals) and NICE CG83 (rehabilitation after critical illness).
- In the three records we reviewed, the nursing documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with trust and professional standards.
- In the three records we reviewed, the medical documentation was complete, in line with trust and professional standards and recorded that care was delivered in line with GPICS. For example, there was evidence of a consultant review on admission to critical care and of daily input from the multidisciplinary team.
- Fifty percent of staff in the service had completed information governance training. This was worse than the trust target of 80%.

Safeguarding

- Staff we spoke with were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Ninety five percent of critical care staff had completed safeguarding adult's level one training. This was better than the trust target of 80%.
- One hundred percent of critical care staff had completed safeguarding children level one training and 87% of staff had completed safeguarding children level two training. This was better than the trust target of 80%.

Mandatory training

- Mandatory training included moving and handling, resuscitation training, fire safety and conflict resolution.
- Staff we spoke with told us senior staff supported them to attend mandatory training and complete electronic learning modules.
- Information reviewed during inspection showed that the overall compliance with mandatory training in the service was 86% at January 2017. This was better than the trust target of 80%.

Assessing and responding to patient risk

- At our unannounced focussed inspection in May 2016, we raised concerns about the remote monitoring of ward patients who were on telemetry (equipment used to monitor the heart rhythm of patients). At that time the telemetry screen was not constantly monitored by staff and staff on CCU told us they did not have time to monitor the screen. At this inspection, we saw the trust had introduced a new process for the monitoring of telemetry patients and staff had access to the standard operating procedure on the intranet.

- Staff we spoke with on CCU understood their responsibilities for monitoring telemetry patients. We observed staff observing the monitoring screens and the nurse in charge completed a log for telemetry patients at the end of each shift. The trust had installed additional monitors on CCU and introduced a bleep system, so CCU staff could contact the ward the patient was based on promptly.
- The Acute Care Team (ACT) supported patients stepped down from critical care and reviewed patients alerted to them by emergency department (ED) and ward staff. The team also supported patients requiring non-invasive ventilation outside of critical care in line with the trust policy. The ACT was available 24 hours a day, seven days a week.
- Information provided by the trust showed that, between April 2016 and March 2017, the ACT responded to 1385 referrals from the wards and ED and followed up 195 patients discharged from critical care.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- Staff on the unit completed a sepsis screening tool that was printed on the physiological observation chart.
- The patient records we reviewed all included completed risk assessments for VTE, pressure areas and nutrition.
- The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Nursing staffing

- Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patient's ratio for level two patients. The staffing ratio for coronary care patients, who were level zero or one, was one nurse to four patients.
- The unit displayed the patient dependency and actual staffing figures.
- The nurse in charge recorded the dependency of patients on the electronic patient record so bed managers, matrons and other senior staff could view live data on patient dependency and staffing.
- Information we reviewed during the inspection, showed the unit's establishment for registered nurses was 36 whole time equivalent (wte) and for health care support workers was six wte. The unit did not have any vacancies.
- The unit had one wte lead nurse, one wte trainee advanced critical care practitioner and 0.5 wte clinical educator. This was in line with GPICS standards.
- The trust provided information on the fill rates for registered nurses. The fill rates were 97% for day shifts and night shifts in December 2016, 101% for day shifts and 99% for night shifts in January 2017 and 96% for day shifts and 98% for night shifts in February 2017.
- The planned staffing figures did not include a supernumerary clinical co-ordinator; however, the lead nurse was available on the unit Monday to Friday. GPICS standards state units with less than six beds may consider a supernumerary clinical co-ordinator to cover peak activity periods. Although this CCU was staffed to nurse seven critical care patients, we reviewed two weeks of patient dependency in January 2017, and there were not seven critical care patients on the unit every day. Therefore the lead nurse supported staff on the unit in a supernumerary capacity when required.
- Information provided by the trust showed the bank and agency usage for registered nurses, between February 2016 and January 2017, was 0.4%. This was in line with GPICS standards.
- The unit used an agency that provided critical care trained staff. The nurse in charge of the shift completed an induction with agency staff new to the unit. However, this was not documented, so we did not see evidence that this had taken place. We did see evidence that agency staff and the nurse in charge signed a record of equipment that the member of agency staff felt they were competent to use.
- The ACT was staffed for at least one band seven nurse and one senior health care support worker in the day and at least two band seven nurses at night seven days a week.
- We observed an evening handover; this was held in a private room on the unit. Staff used a printed sheet from the electronic patient record and the nurse in charge provided clear patient information. The nurse in charge allocated nurses to patients and considered continuity of care and the experience and skill mix of the staff. Staff

then completed a bedside handover with the nurse that had been caring for the patient; this included an update on the treatment plan, review of medications and two person check of equipment.

Medical staffing

- Critical care had a designated clinical lead consultant.
- The consultant establishment was 16 wte. Six of these were consultants in intensive care medicine who were supported by 10 consultant anaesthetists who all had previous training in intensive care medicine. The consultants had recently changed their work pattern to deliver continuity of care which was in line with GPICS standards.
- We saw evidence in the patients record that twice daily consultant led ward rounds were completed Monday to Friday which was in line with GPICS standards, however, ward rounds only took place once a day at the weekend.
- Two middle grade anaesthetic doctors were on site overnight and were supported by the on-call consultant who was not routinely on site. This was not in line with GPICS standards; however, at the time of the inspection the trust was actively recruiting staff grade doctors .
- We observed a multidisciplinary handover where staff discussed all patients and worked collaboratively to develop a management plan.

Major incident awareness and training

- Staff we spoke with understood the fire evacuation plan, however, the risk assessment we saw stored on the unit, had been due for review in 2011.
- Senior staff were able to clearly explain their continuity and major incident plans. The actions described were in line with the trust's major incident and contingency plans.
- Staff knew how to access the major incident and contingency plans on the intranet.

Are critical care services effective?

Good

We carried out this inspection because, when we inspected the service in March 2016, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'good' for effective because:

- The service had taken action on the issues raised in the 2016 inspection. For example, the unit had a dedicated clinical educator, staff took action to review the out of date evidence based guidelines and the service now held records of staff who had received training for specialist equipment, and kept a central record of 'self-assessment competency' of equipment.
- Care and treatment was planned and delivered in line with current evidence based guidance.
- The service participated in national and local audit and patient outcomes were in line with similar units.
- Staff were supported to maintain and develop their professional skills. The number of nursing staff who had an up-to-date appraisal was better than the trust's target.
- Forty nine percent of nurses were studying towards or had a post registration qualification in critical care. This was better than 38% that we found at our 2016 inspection and was nearly in line with the Guidelines for the Provision of Intensive Care Services 2015 (GPICS) minimum recommendation of 50%.
- We observed patient centred multidisciplinary team working.
- Staff assessed patients' nutritional and hydration needs and met these in a timely way.

However,

- A consultant was available and completed a ward round seven days a week. This was not fully in line with GPICS recommendations as not all the consultants who worked on the unit were consultants in intensive care medicine.
- Staff we spoke with had a limited understanding of the deprivation of liberty safeguards (DoLs).

Evidence-based care and treatment

- The unit's policies, protocols and care bundles were based on guidance from National Institute of Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). Staff demonstrated awareness of the policies and knew where to access them. The intranet alerted senior staff by email when a policy or protocol was due to be reviewed.

Critical care

- The unit had an up to date delirium policy and staff assessed patients for delirium in line with NICE guidance. Information provided by the trust showed that an audit of delirium scoring and treatment was underway at the time of our inspection.
- The critical care admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The unit had access to resources from the National Tracheostomy Safety Project.
- Staff completed a sepsis screening tool on the physiological observations chart.
- The physiotherapy team completed a national rehabilitation outcome measure called the 'Chelsea Critical Care Physical Assessment Tool', a scoring system to measure physical morbidity in critical care patients.
- The Acute Care Team (ACT) worked with the nurse consultant and staff on the ward to audit whether care on the wards was delivered in line with NICE CG50 acutely ill patients in hospital. This audit found that 96% of ward patients had clear plans of care documented, but the plans didn't always include the frequency of physiological observations as recommended by NICE CG50.
- The multidisciplinary and senior team in critical care had completed audits of compliance and gap analysis work against the D16 service specification for adult critical care and NICE CG83 rehabilitation after critical illness. Actions that were needed to improve compliance were included on the critical care ward improvement plan.

Pain relief

- A pain management specialist nurse visited the unit and reviewed patients who were receiving pain relief infusions. Staff referred other patients that would benefit from review.
- We observed staff assessing pain using the trust scoring system and giving support to patients who required pain relief.

Nutrition and hydration

- Nursing staff assessed patients' nutritional and hydration needs using the malnutrition universal screening tool (MUST).
- 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.
- A dietitian visited the unit daily. We were informed a speech and language therapist attended the unit when staff referred patients.
- During our inspection we observed water was available and within reach for patients who were able to drink.

Patient outcomes

- We reviewed the 2016 annual Intensive Care National Audit and Research Centre (ICNARC report) showed risk adjusted hospital mortality was 1.1. This was within the expected range.
- The ICNARC data from 1 April to 30 September 2016, showed the unit had a 1% unplanned readmission in 48 hours rate. This was in line with similar units.
- The ICNARC data clerk worked with clinical staff to collect information the service used for research and audit.
- The acute care team (ACT) collected activity data and patient outcomes in an electronic database. This showed the number of referrals the team received from the wards and ED and the number of critical care patients staff followed up on discharge.

Competent staff

- Information provided by the trust showed that all staff on critical care had an up to date appraisal. Staff we spoke with found their appraisal a useful process and gave examples of senior staff supporting their development through the appraisal process.
- Information provided by the trust showed that 49% of nurses were studying towards or had a post registration qualification in critical care. This was better than 38% that we found at our 2016 inspection and was nearly in line with the GPICS minimum recommendation of 50%.
- The unit now had a 0.5 whole time equivalent clinical educator which was in line with the GPICS standards.
- Nurses completed the national competency framework for adult critical care nurses. The clinical educator supported staff and monitored progress against completion with senior staff through the appraisal process.
- Nurses in the ACT completed additional clinical skills, for example, clinical assessment and arterial blood gas sampling.

- New members of nursing staff received an induction onto the unit, were allocated a mentor and had a six week supernumerary period.
- During our 2016 inspections, we raised concerns that the unit did not keep a central log of nursing staff that had training on specialist equipment, and that the unit did not have a process to review nurses self-assessment of competency using high risk equipment. At this inspection we saw the service now held records of staff who had received training for specialist equipment and the clinical educator kept and reviewed a central 'self-assessment competency' log. Training was delivered by company representatives, the clinical educator or trained super users for the equipment. We saw evidence that staff completed the self-assessment every six months.
- The service had opened a training suite in June 2016 on the unit, to support staff with supervised training, assessment and simulation exercises. The unit had introduced monthly multidisciplinary teaching.
- Staff we spoke with told us the leadership team supported them with additional training, for example, teaching and counselling courses.
- Twenty five nurses of the 36 wte staff (69%) had completed critical care transfer training. This training was provided by the trust or by the regional critical care network. This meant the service was not assured that there would always be a nurse trained in transfer of the critical care patient on duty on every shift. However, we did not see evidence that this had impacted on patient care.
- Staff in the ACT delivered education in the trust, for example, high flow oxygen, non-invasive ventilation, intra venous competencies and an acute illness management course.
- Senior staff had undertaken training in relation to appraisals, sickness and performance management.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit, during the ward round and at the bedside during our inspection.
- There was a lead physiotherapist, dietitian and pharmacist for critical care. Staff told us they had access to occupational therapy and speech and language therapy when required.
- We saw in records that when staff made referrals to the multidisciplinary team they responded promptly within 24 hours.
- The unit had a ward clerk, an ICNARC data clerk and had recently appointed to a new post of a housekeeper.

Seven-day services

- A consultant was available and completed a ward round seven days a week. However, this was not fully in line with GPICS recommendations as not all the consultants who worked on the unit were consultants in intensive care medicine.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapists provided treatment seven days a week and an on-call service was available overnight.
- A specialist critical care pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients' medicines. The pharmacy was open seven days a week with a 24 hour on call service.

Access to information

- Staff could access guidelines, policies and protocols on the critical care area of the intranet.
- Staff we spoke with knew where to access guidelines and policies electronically and were able to demonstrate this. They also had access to a folder at the bedside with guidelines and contact details in.
- Staff were able to access blood results and x-rays via electronic results services.
- Staff completed discharge paperwork for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital.
- A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- We saw evidence in two patients' records that staff had best interests discussions with relatives.
- There was evidence in the patient record that staff reviewed sedation regularly. All patients had a sedation score completed, where appropriate.

Critical care

- Staff we spoke with demonstrated an understanding of consent and the Mental Capacity Act (MCA). They told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- Ninety-four percent of staff in the service had completed mental capacity act training. This was better than the trust target of 80%.
- Staff we spoke with were able to explain the process they would follow for the use of restraint and where they would document this. The trust policy on restraint was up to date; this was a trust wide policy with no appendix or section with specific considerations to critical care patients.
- Most staff we spoke with had a limited understanding of the deprivation of liberty safeguards (DoLs). Guidance was available to staff on the unit's intranet site and staff we spoke with knew how to access this.

Are critical care services caring?

Good

When we inspected the service in March 2016, we rated caring as 'good'.

At this inspection we rated the service as 'good' for caring because:

- All the feedback from patients and relatives was positive about the way staff treated them.
- We observed all staff responded to patients' requests in a timely and respectful manner.
- Patients were supported, treated with dignity and respect, and were involved in their care.
- All staff communicated in a kind and compassionate manner with both conscious and unconscious patients.

Compassionate care

- Thank you cards and feedback from patients and relatives were on display. The cards we reviewed contained feedback such as; "exemplary care and brilliant treatment," "despite feeling vulnerable I was made to feel assured and confident I was in safe and capable hands with personal attention to my care and treatment" and "all your staff were just fantastic."
- We observed curtains being drawn around patient's beds and do not enter signs being used when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- During our inspection we observed that all staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- The patients we spoke with told us staff were "kind and they delivered marvellous care."

Understanding and involvement of patients and those close to them

- Patients we spoke with told us all staff introduced themselves and explained their treatment in a way they could understand.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- We observed staff explaining to patients what was happening during care delivery. Staff we spoke with felt they were able to support patients and relatives and explain their care to them.
- During a ward round, we observed staff consider the impact of an acute admission of a patient on a relative and staff offered support to the relative. A relative we spoke with told us they were happy with the care their relative received and also the amount of information staff gave to them. Another relative who was unable to visit, was given a password by staff so they could receive information over the phone.
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation. The unit had a link nurse and lead consultant for organ donation.

Emotional support

- Staff provided the opportunity for a patient diary to be kept in consultation with their relatives. Staff and relatives made entries in the diary during the patient's stay on the unit.
- Staff we spoke with told us they had access to chaplains who would visit the unit at patients or relatives request.

Critical care

- During our inspection, we observed a discussion regarding patient treatment limitations between the critical care consultant and medical consultant. The discussion was sensitive, patient centred and caring.
- Staff we spoke with showed a good understanding of end of life care. The unit was introducing resources such as memory boxes for relatives of patients who were approaching the end of their life.
- The acute care team provided emotional support for patients on the ward following discharge from critical care.
- Staff had access to a psychologist and could refer patients if required.

Are critical care services responsive?

Requires improvement

We carried out this inspection because, when we inspected the service in March 2016, we rated responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'requires improvement' for responsive because:

- Some of the issues raised at the 2016 inspection remained a concern. For example, the unit's bed days of care post eight hour delay rate was worse than similar units and at the time of the inspection there was no follow up or support to critical care patients following discharge from hospital.
- The arrangements for coronary care beds for level one and zero dependency patients within the same location as critical care patients of level two and three dependency was not in line with the national service specification. The trust had approved a business case for relocation of the four beds; however, the surgery and critical care leadership team were unable to confirm the date for the implementation of this .
- The service did not have access to patient and relative support groups.
- We could not be assured that the mixed sex accommodation breach information the service collected was reliable.

However,

- The unit had received no formal complaints between April 2016 and March 2017.
- Staff took account of, and were able to meet people's individual needs.

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional critical care network.
- Critical care provision was flexed to meet the differing needs of level two, three and also coronary care patients, who were level one or zero. The trust had approved a business case to relocate four coronary care beds to a new location in the hospital to enable the anaesthetic and critical care nursing team to manage the critical care unit as a closed unit in line with the national service specification and the Guidelines for the Provision of Intensive Care Services 2015 (GPICS).
- The rehabilitation after critical illness service was limited. The acute care team and allied health professionals provided support to patients on the ward following discharge from critical care, however, at the time of the inspection there was no follow up or support to patients following discharge from hospital. This was not in line with GPICS or the National Institute of Health and Care Excellence (NICE) CG83 rehabilitation after critical illness. Staff had visited a local unit and were in the process of setting up a follow up clinic that was due to start two months after our inspection. The senior management team supported the staff with time to run the clinic, however, a business case or formal funding had not been agreed.
- The service did not have a critical care patient and relative support group.
- A visitors' waiting room was available on the unit which contained information and leaflets for visitors, drink making facilities, a television and radio.. The unit had a separate room for staff to meet with relatives for private conversations.

Meeting people's individual needs

- Staff we spoke with knew how to access translation services for patients whose first language was not English. A guide was available on the intranet that explained the process in and out of hours.

- The unit had three dementia champions and used the butterfly scheme for people living with dementia. Staff had access to a completed butterfly scheme care plan to use as a resource. The unit had access to memory trolleys in the trust.
- Staff we spoke with felt able to support patients with dementia on the unit. Ninety three percent of critical care staff had completed dementia awareness training. This was better than the trust target of 80%.
- Staff we spoke with felt confident to care for patients with a learning disability and would seek support from the nurse in charge on the unit if they needed it.
- Staff we spoke with told us they could access equipment to care for bariatric patients and had not experienced delays to patient care.

Access and flow

- 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. An acute admission flow chart to ICU/HDU Monday to Friday 8am to 5pm was displayed with a footnote about admissions out of hours.
- Two records we reviewed for patients, showed staff recorded the time of the decision to admit the patient to critical care; both patients arrived in critical care within four hours. This was in line with GPICS standard.
- Bed occupancy had been below the England average from July 2016 up to the time of our inspection. The trust had closed one level three bed following our unannounced inspection in May 2016 due to staffing concerns. This bed remained closed at the time of this inspection.
- Information provided by the trust on the patient safety scorecard showed six patients had been ventilated outside the unit for more than four hours between April 2016 and January 2017.
- The Intensive Care National Audit and Research Centre (ICNARC) data from 1 April to 30 September 2016 showed the unit had transferred 0.4% of patients due to non-clinical reasons. This was in line with similar units.
- The ICNARC data from 1 April to 30 September 2016 showed the bed days of care post eight hour delay rate was 8.1%. This was worse than similar units' rate of 7.6%.
- The ICNARC data from 1 April to 30 September 2016 showed the bed days of care post 24 hour delay rate was 4.7%. This was in line with similar units.
- The ICNARC data from 1 April to 30 September 2016 showed the out of hours discharge to the ward rate was 3.9%. This was about the same as similar units' rate of 3.5%.
- The unit did not have a clear process for identifying, recording and reporting mixed sex accommodation breaches. We reviewed the monthly mixed sex recording form for March 2017. Staff had recorded inaccurate information, for example, a male and a female level three patient were recorded as a mixed sex accommodation breach, however, critically ill patients are not classed as a breach in the Department of Health guidance (2010). Staff recorded male and female coronary care patients as not a mixed sex accommodation breach, however, on review of the handover documentation none of the patients were defined as critically ill (level three or two patients) and therefore would be classed as a breach in line with the Department of Health guidance.
- We reviewed the trust policy was which was based on Department of Health guidance (2010), however, the trust policy stated staff had eight hours to move a patient before they were classified as a mixed sex breach. Staff did not record the time any patient was classified as a mixed sex occurrence or the time the patients were moved on the monthly recording form. Senior staff told us this information would be available on the electronic patient record.

Learning from complaints and concerns

- The unit had received no formal complaints between April 2016 and March 2017.
- Staff we spoke with understood the process for managing concerns and how patients or relatives could make a formal complaint.
- The unit displayed information on how to make a complaint.

Are critical care services well-led?

Requires improvement

We carried out this inspection because, when we inspected the service in March 2016, we rated well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

Critical care

At this inspection we rated the service as 'requires improvement' for well led because:

- Although there had been improvement, some of the issues raised at the 2016 inspection remained a concern. For example, the strategy for critical care was based on an operational review of the progress the service had made since the 2016 inspection and there was limited evidence available to show that the service had improved the arrangements for the management of risk.
- The senior management team were unable to share evidence of a long term strategy for critical care. Staff knew the future of the unit was for coronary care to move to another ward, but they were unable to tell us of a longer term vision or how critical care linked in to the trust's strategy.
- The leadership team demonstrated a reactive approach to risk assessment and risk management. Some of the unit's risk assessments had been written between 2009 and 2013. There was no evidence that staff had reviewed the risk assessments since these dates.
- The critical care improvement plan we reviewed, had been updated in March 2017.However, no actions had been added to the plan since September 2016.
- The service had not undertaken any formal patient or relative surveys or any public engagement in service planning.

However,

- There had been a significant change to the leadership team since our 2016 inspections. All staff were positive about the team and found them supportive, approachable and visible.
- Morale on the unit had improved; staff told us the unit felt like a different place to the one they worked on during our 2016 inspection.
- Staff who had worked in the trust for a long period of time told us that the morale and culture had improved and they felt listened to and valued by all levels of staff in the trust.
- Staff engagement had improved since our 2016 inspection. The new leadership team held monthly senior staff and multidisciplinary meetings.

Leadership of service

- There was a lead consultant and a lead nurse for critical care. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.
- There had been a significant change to the leadership team since our 2016 inspections. All staff we spoke with were positive about the team and found them supportive, approachable and visible.
- Staff we spoke with told us the executive team were visible and visited the unit regularly. Staff told us they felt the executive team recognised the improvements the unit had made.
- The leadership team were very proud of all the staff, the improvements and changes they had made in the service and of the quality of patient care the staff provided.
- It was clear that staff had confidence in the unit's leadership. All staff we spoke with reported feeling supported by their team and managers.
- Senior staff had completed leadership and management courses, appraisal and root cause analysis training. They felt their development needs were met and supported by the leadership and executive team.

Vision and strategy for this service

- The senior management team told us their vision was to have a high quality closed critical care unit that was in line with the trust strategy. The evidence they provided was a report the team had submitted to the trust board. We reviewed this report and found this to be an operational review of the progress made in critical care following the 2016 inspection and the ongoing challenges faced by the service. It included an options appraisal for the change to the delivery of coronary care.
- The senior management team were unable to share a longer term strategy with us, for example, they were unsure of the bed base critical care would require once coronary care was moved as they had not completed any capacity and demand work for the unit.
- Staff we spoke with told us they knew the future of the unit was for coronary care to move to another ward and for critical care to continue to work on the actions in the critical care action plan. They were unable to tell us of a longer term vision or how critical care linked in to the trust's strategy.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Critical care

Governance, risk management and quality measurement

- 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 progress notes were recorded. Examples on the unit's risk register included ward clerk resources, lack of intensive care medicine consultant cover at the weekend, failure to comply with health building note guidance, lack of follow up service and the potential to breach patient confidentiality on the additional telemetry screens. We reviewed the electronic risk register during our inspection and found it contained evidence of controls and mitigation. Senior staff entered regular updates of the risks on the risk register.
- The service had introduced monthly critical care assurance group meetings that the leadership team attended. We reviewed three sets of minutes from these meetings; there was evidence of discussion of the critical care action plan, finance, staffing, and incidents. However, the minutes did not give clear evidence or assurance that the leadership team reviewed the risks on the risk register and discussed the need to escalate any of the risks. We spoke with the leadership team about this, who informed us they had held an additional meeting in March specifically to review the risk register. We requested to review the minutes from this meeting, however, none had been taken.
- The leadership team told us they would escalate concerns from the critical care assurance group to the monthly surgical quality and safety governance meeting. We reviewed the minutes from this meeting provided by the trust. These showed poor attendance, limited discussion of risk register or issues escalated from critical care.
- The leadership team appeared to have a reactive approach to risk assessment and risk management. We reviewed some of the unit's risk assessments for tasks and situations that were not significant enough to include on the risk register. These were stored electronically and had been written between 2009 and 2013. There was no evidence that staff had reviewed the risk assessments since these dates. The unit's fire risk assessment had been due for review in 2011; there was no evidence the copy of this that staff used on the unit to complete the fire checks had been reviewed.
- The trust had introduced the patient safety scorecard as part of quality measurement. The unit also participated in monthly reporting of operational and quality measures to the regional adult critical care operational delivery network.
- Following our 2016 inspection, the service had participated in two peer reviews; we saw evidence of a report following a peer review visit from a local NHS trust written in April 2016 and a regional adult critical care operational delivery network peer review report written in January 2017. The outcomes of the local NHS trust peer review had been incorporated into the unit's ward improvement plan. The actions from the regional adult critical care operational delivery network peer review had been incorporated in the strategic workforce plans and were recorded on the unit's risk register if appropriate.

Culture within the service

- Senior staff had worked to improve the morale on the unit. All staff we spoke with told us the unit felt like a different place to the one they worked on during our 2016 inspection. Staff who had worked in the trust for a long period of time told us that the morale and culture had improved and they felt listened to and valued by all levels of staff in the trust.
- Staff we spoke with told us they were much happier in their work, felt supported, to raise concerns and that the culture on the unit was open and honest with a focus on patient care and safety.
- Staff were proud of the team they worked in and of the care they were able to give to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- Senior staff had worked to improve the sickness rate in the service. Information provided by the trust showed the average sickness rate in the critical care between March 2016 and February 2017 was 6%. Senior staff managed sickness with support from the human resources and occupational health teams in line with trust policy.

Public engagement

Critical care

- The unit displayed thank you cards from patient and relatives.
- The unit did participated in the friends and family test, however, did not complete a formal patient or relative survey.
- The service had not undertaken any patient or relative engagement in the planning and setting up of the critical care follow up clinic.

Staff engagement

- Staff engagement had improved since our last inspection. The new leadership team held monthly senior staff and multidisciplinary meetings. Staff were given the time back if they attended in their own time. We saw evidence in the minutes that leadership, staff morale, the performance dashboard, the critical care action plan, incidents and complaints were discussed. Minutes of the meetings were available for staff to read in the staff room. Staff we spoke with told us they also received the minutes by email.
- Staff shared information through a communication book and noticeboard in the staff room. Urgent issues were communicated verbally by the lead nurse and the nurse in charge at handover and at the safety brief.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- The service had one advanced critical care practitioner in training.
- The unit introduced a housekeeper role to support patients and enable the nursing staff to focus on patient care at the bedside.
- The service had introduced a visual countdown in the electronic patient record to highlight patients whose discharge may be delayed.

Maternity and gynaecology

Safe	Good
Well-led	Good
Overall	

Information about the service

The trust offered a range of maternity and gynaecology services for women and families based in the hospital and the community setting across West and North Yorkshire and East Lancashire. Services offered included early pregnancy assessment, homebirth for women with low-risk pregnancies to specialist care for women who needed closer monitoring.

There was an early pregnancy assessment unit for women under 18 weeks of pregnancy and gynaecology assessment and treatment unit based on ward 20 (location B16); this ward was also a surgical day-case unit which took some gynaecology patients.

Gynaecology inpatient services were provided on ward 13 (location A28) which had 30 beds and also admitted female general surgery patients.

Labour ward (building 1) had eight delivery rooms; four were low risk midwife-led delivery rooms, which had active birth equipment. Two rooms had birth pools There were four consultant led delivery rooms for higher risk deliveries, these also had active birth equipment. There was a four bedded induction bay and also a discharge lounge if required. There was direct access to the obstetric theatre and anaesthetic room.

There were six teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics and general practitioner surgeries and children's centres.

The maternity assessment centre was available Monday to Friday 08.00 to 20.00, for women over 18 weeks pregnant. Antenatal clinics were held in the hospital and also in a local town. The hospital had two ultrasound scanning rooms; these were in main x-ray.

Antenatal and postnatal care was provided on ward 21 (location B18), which had 15 beds, a dining room and discharge lounge.

Maternity services at Airedale NHS Foundation Trust delivered 2,142 babies between October 2015 and September 2016.

The trust did not provide a surgical or medical termination of pregnancy service.

In March 2016, CQC carried out an announced comprehensive inspection. We rated safe as requires improvement and effective, caring, responsive and well led as and as good. The service was rated good overall.

During the 2016 inspection, we identified the service must ensure that daily checks were carried out on all emergency equipment in line with trust policy. Additionally, the service should consider taking action on the following six points to improve; develop a maternity and gynaecology strategy to give direction and achievable objectives; add safety briefings as part of to the communication with staff in maternity services; review the 'scrub' midwife role on the labour ward and staffing establishment in maternity; consider submitting and displaying data to the maternity safety thermometer; audit the compliance of MEOWS charts on the labour ward and have systems in place to ensure investigations, including root cause analyses, are completed in a timely manner and in line with national guidance.

During this inspection, we inspected the key questions of safe and well-led. We visited the antenatal and postnatal ward (ward 21, B18), labour ward (Building 1), maternity assessment centre, early pregnancy assessment unit and gynaecology assessment and treatment unit (ward 20, B16) and ward 13 (A28). We spoke with 40 staff including service leads, ward leaders, midwives, nurses, health care support workers, administrators and domestics. We reviewed nine sets of maternity records, and 10 prescription charts.

Maternity and gynaecology

Summary of findings

We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection we rated safe and well-led as good because:

- Processes had been put in place to ensure staff had checked emergency equipment. Staff also knew how to check equipment and what to do if there were any concerns.
- Staff were aware of how to report incidents and were confident they would be investigated and findings shared throughout the service. We found a no blame culture and there were good working relationships between the medical, nursing and midwifery staff.
- There were effective infection prevention and control practices in maternity; when we highlighted some areas of concern these were immediately rectified.
- There were effective processes in place to ensure that risks were managed appropriately this included safeguarding and risk assessments. We found documentation was of a good standard, with monthly audits, which helped to maintain standards.
- The service had enough staff to care for the number of patients and their level of need. Staff knew and put into practice the service's values and they knew and had contact with managers at all levels, including the most senior.
- The senior management team were visible within the service and had an open door policy. There were plans in place to move the service forward to support the changing needs of their commissioners and the local community. During our inspection we observed good cross directorate working between the senior management team and the surgical directorate.

However:

- There was a discrepancy between the training data provided by the trust and the directorate data. Attendance by medical staff was significantly below the targets set by the trust.

Are maternity and gynaecology services safe?

Good

We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection, we rated safe as good because:

- We found checks on emergency equipment had improved; neonatal resuscitaires and fridges were complete. Staff were aware of processes should fridge temperatures fall outside of the expected range.
- There were effective systems for reporting, investigating and acting on adverse events. Measures had been put in place to ensure root cause analyses were completed in a timely manner. We saw evidence of sharing learning through staff meetings and reviews.
- The service had reviewed the role of the scrub midwife as previously recommended.
- There were no cases of hospital acquired infections in the year prior to our announced inspection.
- Modified early obstetric warning scores (MEOWS) were audited monthly. We also found them to be complete and appropriately escalated in the patient records we reviewed during inspection.
- There were clear safeguarding processes in place; staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed.
- Staffing levels and community midwifery caseload numbers were better than national recommendations.
- Medical staffing was in line with national recommendations for the number of babies born in the unit each year.
- Clinical records were completed to a high standard, which included risk assessments throughout pregnancy, labour and postnatal care.
- Directorate level data showed that midwifery attendance at mandatory and safeguarding level three data was better than the trust target.

However:

- The service continued to not submit data to the maternity safety thermometer.
- There was a lack of assurance that defective equipment had been reported.
- We were concerned with some infection prevention and control practices on ward 13 (A28), which included medical staff not cleansing their hands and clean linen and cleaning products being stored in the corridor.
- We found the named midwife was not always documented
- The trust reported mandatory and safeguarding training was not accurate compared to directorate level training data.
- Attendance by medical staff at mandatory training was below the 80% required by the trust.

Incidents

- The trust had policies for reporting incidents, near misses and adverse events. All staff we spoke with were aware of the process to report incidents. We saw a printed list in clinical areas which detailed what incidents should be reported. Staff reported incidents on the trusts electronic incident reporting system. Staff told us they received information on incidents they had reported.
- Between February 2016 and January 2017, 758 incidents were reported; five were reported as moderate harm, 307 were reported as low harm/minor and 412 were reported as no harm. There were no specific identifiable themes noted.
- There were no never events reported between February 2016 and January 2017. 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.
- Between February 2016 and January 2017 the trust reported no serious incidents to the NHS strategic executive, information system (STEIS).
- We reviewed five root cause analysis (RCA) reports. We found that these were all completed in a timely manner and action plans were in place to mitigate a recurrence. The lead investigator for a RCA is provided with a timeline with actions and due dates for completion of the investigation.
- Senior staff reviewed incidents daily and categorised the level of harm. Case review meetings were held weekly on the labour ward led by an obstetric consultant. These meetings were attended by all staff and notes of these meetings were kept on the labour ward for all staff to review.
- Staff told us feedback from incidents was provided in a number of ways including monthly ward meetings, face to face feedback, monthly risk bulletins and emails.
- We reviewed evidence of monthly perinatal mortality meetings. We found evidence of discussion of clinical cases and recommendations to improve clinical care.
- Most staff we spoke with were aware of the duty of candour. Some were not aware of this terminology, but were aware of the importance of being open and transparent with patients. Duty of candour is a legal duty of hospital trusts to inform and apologise to patients if there have been mistakes in their care which have led to significant harm. We reviewed five examples of duty of candour letters to patients; these all informed patients of a key point of contact and also realistic timescales for investigations to be completed.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- Safety thermometer data was displayed on ward 13 (A28) for 2016 to 2017\. We found that there were three falls and 15 grade two pressure ulcers. There were no pressure ulcers grade three of four reported, which are more serious.
- The maternity safety thermometer allows maternity teams to monitor and record the proportion of mothers who have experienced harm free care. This includes data about perineal and or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. Additionally, it reports babies born with an Apgar score (a check used by midwives and doctors the condition of a new born) and those admitted to a neonatal unit.
- The maternity department did not submit data to the maternity safety thermometer although this was recommended in our previous report. The Trust explained they considered the CQC recommendation from our last report and concluded they wanted to have a continuous data collection of all of the safety

thermometer metrics rather than a once-a-month snap shot. Therefore the data collected and displayed includes the majority of the maternity thermometer metrics with the addition of additional questions on the real time patient satisfaction survey regarding maternal psychological well-being. We saw information about key performance indicators displayed on labour ward (Building 1) and ward 21 (B18). This information included 3rd degree tears, the caesarean section rate and the number of midwives to women ratio

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired infections such as Methicillin-resistantStaphylococcus aureus(MRSA) and C. difficile reported between March 2016 and February 2017.
- The trust carried out monthly hand hygiene audits. Between February 2016 and January 2017 compliance was varied within the women and children's group. Compliance on ward 13 (A28) was between 90% and 100%. Ward 21 (B18) was between 93% and 100%. Labour ward (Building 1) was between 82% and 100%. Antenatal Clinic was noted to be between 98% and 100%.
- We observed staff using personal protective equipment, when required, and adhered to the bare below elbow guidance.
- There were hand gel dispensers available at the entrance of each ward and by each bed. We observed most staff cleansing their hands on entrance to the ward areas, with the exception of two medical staff who did not cleans their hands on the entrance to ward 13 (A28).
- Staff followed best practice with infection control and prevention principles, in relation to the management of clinical waste.
- On ward 13 (A28) we observed some areas of concern, for example, clean linen on trolleys in the corridor with cleaning products, used towels were in an open laundry skip in a bathroom and an open sharps bin by the nurses station.
- Infection prevention and control (IPC) training was part of the trust mandatory training. Training records provided by the trust showed that 80% of staff had undertaken level one IPC training, and 79% of staff had undertaken level two IPC training. We spoke with the training development midwife who identified that IPC training was part of the maternity mandatory training days and compliance data for this was found to be 100%.
- We found high level dust on the labour ward in one of the delivery rooms, and dust on the emergency trolley and trollies which were prepared for instrumental deliveries. We highlighted this with staff and found that all of our concerns had been resolved the following day.
- During our announced inspection, we found pipe storage cupboards which were unlocked; some had been converted into storage cupboards for linen and equipment which may be needed quickly. We found one cupboard which contained four plastic watering cans in the bottom of it. We were concerned this may be an IPC risk, if stagnant water was in the watering cans and also a fire risk; we highlighted our concern with staff. During our unannounced inspection we found the items had been removed and placed in the garden area.
- We found dust on the emergency trolley on ward 21 (B18).We highlighted this with staff during our inspection and it was actioned immediately, we were advised that it would be highlighted with staff who are responsible for cleaning the emergency equipment.

Environment and equipment

- We found checks were completed on all emergency equipment in the three months prior to our announced inspection.
- On labour ward and ward 21 (B18) we found that checks on all neonatal resuscitaires; we found them to be complete for the three months prior to our announced inspection.
- All entrances to labour ward and ward 21 (A28) were by a telecom system. Staff gained entry using a swipe card system, and the doors automatically released, for exit. Closed circuit television (CCTV) cameras were installed at the entrances of both labour ward and ward 21 (A28). To exit to the wards, visitors and staff walked up to the doors and they unlocked.
- There was adequate equipment on the maternity unit to ensure safe care. Staff confirmed that had sufficient equipment to meet patients' needs.
- On the labour ward there were eight delivery rooms all of which had en-suite facilities. Four rooms were consultant led and four were midwifery led. We found rooms had active birth equipment and two of the midwife led rooms had birthing pools. We found

damage to a wall in the en-suite in one of the midwifery led rooms and a shower attachment in one the consultant led delivery rooms, which was not attached to the wall appropriately. We highlighted these concerns with staff.

- We also found a delivery bed which had some split plastic covering; this was a safety risk to women and an infection risk as bodily fluids may be caught in it. We highlighted this concern to staff who were unable to confirm if this had been reported. We returned the following day to check if the bed had been reported. Staff were unable to confirm if the faulty bed had been reported. senior leadership confirmed the bed had been reported. We were concerned that there was no paper trail and assurance that the defective bed had been reported. We reviewed process again during our unannounced inspection. The unit had an equipment diary that was used sporadically to document jobs that have been reported. We found only two jobs documented as reported in 2017 which did not include the damaged delivery bed. The unit continued to rely on verbal hand over when a job had been reported.
- The labour ward had telemetry facilities which enabled high risk women to mobilise in labour and use the birthing pools. All equipment for supporting women to leave the pool in an emergency situation was stored in the delivery room.
- Birthing balls were available for women to use during labour.
- The obstetric theatre and anaesthetic room was accessed from the labour ward. If a second theatre was required there was also access to the theatre suite from the labour ward.
- All electronic equipment we checked which included breast pumps, electric steam sterilizers and foetal monitoring equipment had visible evidence of routine electrical safety testing and when it was next due for service.
- We checked drug fridges on the labour ward, ward 13 (A28) and ward 21 (B18). We found all had high and low temperature readings recorded daily. There were no gaps in recording in the month prior to our announced inspection. Staff we spoke with were able to inform us of the process if there temperatures was recorded outside the normal range.
- We checked the fridge and equipment on ward 13 (A28) where products of conception were stored prior to transfer to the mortuary. We found all checks to be complete and equipment appropriate.
- We reviewed air and oxygen cylinders on resuscitaires. We found all were within use by date and were well maintained.
- There were no ultrasound scan facilities available on the EPAU / GATU, which meant that women were required to walk to main x-ray for early pregnancy scans. Women were then seen back on the EPAU / GATU. We were concerned that women who may have been given non-reassuring results during a scan were then required to walk back to the unit along a public thoroughfare. We were told there was a counselling room within x-ray, and staff from the unit were able to go to this room to counsel women.

Medicines

- There were 29 medication errors reported by these specialties between February 2016 and January 2017, these were reviewed at the monthly Medicines Safety Group and learning shared to reduce the risk of the risk of a recurrence ..
- Medicines were stored in locked cupboards and trolleys in all of the wards we visited. We found intravenous medications (ranitidine and metronidazole) were stored in caesarean section grab boxes; these were stored in an unlocked room, which was off an unlocked corridor. We also found Lignocaine 1% was stored on the bottom of instrumental delivery trollies; these trollies were stored in the same unlocked corridor which was not sign-posted as staff only. We raised this concern with staff as it could be accessed by members of the public who were on the unit. We were advised that a risk assessment had been carried out and it was identified that this was sufficient. We reviewed the content of this risk assessment, it only mentioned the storage of the intravenous ranitidine and metronidazole. On our unannounced inspection, we found that the corridor had staff only signs placed on the doors and the lignocaine had been placed in the locked clean utility.
- Nitrous Oxide (Entonox) was piped into each delivery room on the labour ward. On ward 21 (B18) we found portable Entonox, which was stored appropriately, securely and was within the use by date.

- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All of the fridge temperatures were checked and recorded daily. There were no gaps in recording in the months prior to our announced inspection.
- Midwives told us that they received support from the on-site pharmacist, when required.
- Midwives dispensed 'To Take Out' (TTO) medications when women were discharged from the labour and postnatal ward. We observed robust practices in checking medications with two staff members and appropriate TTO medication charts.
- 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.
- On the labour ward, controlled drugs (CDs) were subject to a two person check twice in a 24 hour period; this would usually occur on handover to the next shift. We reviewed records between 1st January 2017 and March 2017, we found that the CD stock was not subject to a two person check at any time on one day in March, when we questioned staff there was no reason given.
- On ward 21 (A18) we were advised that CDs were subject to a two person check once every 24 hours; this was usually on handover from the night staff to the day staff. We found that a check was missed on the one day in March during the 3 months period between January and March 2017. We highlighted this with senior staff and were assured that this had been discussed staff who were responsible for checking the CDs on that day.
- We checked drug administration records of 10 women and found these to be fully completed; all prescribers had printed their names and provided bleep numbers. We observed patients getting their medications promptly and allergies were checked and recorded appropriately.
- The service undertook monthly prescription chart audits. Between March 2016 and February 2017, we found that compliance was 98% to 100% for all indicators reviewed.
- We found antibiotics were prescribed in line with trust guidance and were reviewed appropriately in the prescription chart.

Records

- Clinical records were completed to a high standard. We reviewed nine random records and all contained a clear pathway of care which described what women should expect at each stage of their pregnancy and labour. We found that the named antenatal midwife was not documented in four sets of records. On all sets of records a sticker was placed over the allocated place for documenting the named midwife, this sticker only had contact numbers and no space to record the name which would act as a prompt.
- Risk assessments were completed at booking and repeated at every antenatal visit.
- Women carried their own records throughout their pregnancy and postnatal period of care.
- The maternity service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- The service used the 'fresh eyes' approach to review continuous foetal heart tracing. An hourly review was completed by the midwife looking after the woman, and this was documented using a prompt sticker in the labour partogram (labour progress notes). Every two hours there was a review by either the labour ward coordinator, doctor or peer. There was also a four hourly review by the labour ward coordinator. All information was updated on the patient care board which was stored in the staff office. We saw evidence of these checks in the notes we reviewed.
- The service submitted monthly record keeping audits into an electronic audit tool. We reviewed audit data between March 2016 and February 2017 and found results to be good.
- We were concerned with the storage of patient records on ward 13 (A28). We observed open patient records which were left unattended on a notes trolley outside of the nurse's station.

Safeguarding

- There were clear and effective processes for safeguarding mothers and babies. The service had a dedicated, midwife responsible for safeguarding children. The safeguarding midwife worked alongside the named nurse for safeguarding children.
- We reviewed one safeguarding record at random and found this to be complete and thorough. It included outcomes for mother and baby at the end of the episode of care.

- Risk assessments and clear care pathways were in place to in line with the safeguarding unborn babies' policy.
- Staff demonstrated they had a good understanding of the need to ensure vulnerable people were safeguarded. Staff understood their responsibilities in identifying and reporting any concerns.
- We were told all staff, including midwives, working across maternity services require either level 2 or 3 safeguarding children training and that all midwives received annual level three safeguarding training. This is in accordance with the trust's 2016 safeguarding children and young people training strategy. Records provided by the trust showed 0% of staff had completed level one child protection training, this is because , 100% of staff had completed safeguarding level two training and staff do not need to complete both. 64% of staff had completed child protection training level 3. We met with the training development midwife who provided us with assurance that safeguarding level three training was part of the annual midwifery mandatory training program and attendance on the program was 100% for midwifery staff.
- Staff were aware of the trust's child abduction policy. All babies on labour ward and ward 21 (B18) had security tags, which triggered an alarm if the baby was removed. Staff on ward 21 (B18) told us security tested the tag system once or twice a week, the ward did not have assurance when this happened. During our inspection, staff identified this was a gap and put processes in place to gain this assurance. Prior to our inspection the infant abduction policy had not been tested. A security incident during our inspection staff were able to test the abduction policy. Following our inspection the service undertook a desktop review of the child abduction policy; we reviewed information following this exercise and found it to be comprehensive with key learning points and next steps.
- The trust had a comprehensive safeguarding policy, which was linked to the statutory 'Working Together to Safeguard Children' (DH 2015). The policy included information and procedures with regard to female genital mutilation (FGM), child sexual exploitation (CSE), patients who do not attend appointments (DNA) and possible abduction.
- Patients on the EPAU and GATU were asked to provide a personal password which was used to maintain confidentiality and safety when calling the unit for test results.

Mandatory training

- The trust mandatory training programme included infection prevention and control, moving and handling, equality and diversity and information governance. We were told this training was coordinated by the training department.
- Compliance with mandatory training for midwifery and health care staff was reported by the training and development department as being 83% overall; this was above the trust target of 80%. We found that information governance compliance was 79%. Training figures provided by the practice development midwife showed compliance was 100% as information governance was included in the obstetric mandatory training programme.
- Medical staff compliance with mandatory training was reported as 76%; basic life support (73%), conflict resolution (73%), equality and diversity (73%), infection prevention level two (73%) and information governance (55%) training were all below the trust target of 80%.
- Staff could access mandatory training either via an electronic learning portal or attend face to face training. Staff we spoke with said they could access training and were given time to do so.
- Staff had a learning passport in which they could record all training attended and reflect upon it. Staff were informed when their mandatory training was due and there was an escalation process for staff who were not up to date with their training.
- Midwifery, health care assistant (HCA) and medical staff attended a two-day obstetric mandatory programme which included emergency drills, adult and neonatal resuscitation, infant feeding, record-keeping and risk management awareness, safeguarding children level three, and Cardiotocography (CTG) interpretation. We found that 100% of Midwives and HCA had attended both days of obstetric mandatory training.
- We were told that staff on ward 13 (A28) did not receive any bereavement counselling training. The gynaecology staff who worked on the ward when it first became a mixed surgical ward had shared their knowledge; there had not been any update since.

Assessing and responding to patient risk

- Midwifery staff identified women as high risk by using an early warning assessment tool known as the modified early obstetric warning score (MEOWS) to assess the

health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed nine records and saw all contained completed MEOWS tools.

- The service undertook monthly audits of five MEOWS records; we found between September 2016 and January 2017 there was 100% compliance. .
- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in obstetric theatre of a modified maternity World Health Organisation (WHO) surgical safety checklist.
- Audit of the maternity WHO checklist was part of the nursing key performance indicators (KPIs), five records were audited monthly and submitted electronically. We found between January and December 2016 compliance was mixed. Signing time in, time out from theatre compliance was between 99-100%, compliance of recording time in and time out from recovery was between 75% and 82% respectively.
- The unit used the 'fresh eyes' approach – a system which required two members of staff to review foetal heart tracings; this indicated a proactive approach in the management of obstetric risks.
- Staff understood the process of escalating concerns if a patient's condition was deteriorating in EPAU, GATU, maternity assessment centre (MAC), Labour ward, Ward 21 (B18) and Ward 13 (A28); this included contacting the acute care team out of hours.
- Consultant obstetricians and gynaecologists were on call out of hours to provide additional support if a patient's condition deteriorated.
- Community midwives completed risk assessments at booking appointments to identify which pathway of care women would follow. We saw evidence of this in all records we reviewed.
- In all records (nine) we reviewed, we found completed risk assessment for venous thromboembolism (blood clots) and Waterlow (pressure area risk assessment).
- We found clear pathways for women suspected of having sepsis (a life-threatening illness caused by the body's response to infection).

Midwifery staffing

- 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) with an average ratio of 1:26 between April 2016 and February 2017; this was better that the recommended 1:28.
- We reviewed data which found that community midwifery caseload sizes were predicted as being 1:94; this was better than the national recommendation of 1:98.
- The service had used the Birthrate Plus® acuity tool in 2010 to assess workload, it had been identified that the complexity of the care had increased; therefore we were informed that the service was going to review this again in May 2017.
- NICE guidelines on safe midwifery staffing (2015) stated all women should receive 1:1 care in labour. The trust indicator for 1:1 care in labour was 90%. We reviewed data which showed between April 2016 and February 2017 1:1 care in labour was achieved 97% of the time; this was better than the trust indicator.
- Following our previous inspection, the service had reviewed the allocation of a scrub midwife. Senior staff we spoke with informed us that this provision was reviewed and found to not impact on provision of 1:1 care in labour. The scrub midwife was allocated to patients who were not actively labouring, for example, women who were being induced. We were assured that there was little impact on staffing as the data provided showed the service was exceeding the indicator set by the trust.
- There was a safe staffing and escalation protocol to follow should staffing levels on a shift fall below the agreed planned level or should demand increase.
- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing numbers.
- The service used bank midwives from their own staffing establishment should shifts require cover; the total hours worked was monitored by management to ensure staff were not working too many hours, which could affect patient safety.
- Staff told us they were concerned with the level of staffing on ward 21 as there were two midwives and one health care assistant (HCA); a HCA was not always guaranteed. We reviewed data which identified there was no HCA available on four shifts in January and February 2017, although on one occasion this was planned. We found that escalation plans did not include moving midwifery staff from ward 21 to the labour ward.

- Ward leaders were supernumerary (not counted in ward establishment numbers), were able to support clinically, if demand increased.
- The service used a formal patient escalation and handover tool (SBAR). The SBAR tool was used to document calls women made to the unit and during formal handovers. Ward 21 recorded staff handover; this was detailed and concise and any additional information was handed over directly between staff.
- Between March 2016 and January 2017, the trust reported an average vacancy rate of 6% in the service. We found there were robust succession plans in place for key roles within the service.
- Between March 2016 and January 2017, the trust reported an average turnover rate of 6%.
- Between March 2016 and January 2017, the trust reported a bank and agency usage rate of 0.4% within the service.

Medical staffing

- The medical staffing mix for the maternity and gynaecology service across the trust was equal to the England average, with 35% consultant grade staff. Middle grade staff, that is doctors with at least three years as a senior house officer or at a higher grade, was 14% at the trust which was higher than the England average of 8%. The trust had lower than the England average for registrar level staff, which formed 43% of the staff, against an England average of 50%. Junior doctors, those in foundation years one or two, made up 9% of staff, with the England average at 7%.
- The delivery suite had consultant cover for 40 hours per week; there was also consultant cover available out of hours. This was in line with the Royal College of Obstetrics and Gynaecology (ROCG) recommendations for the number of births.
- The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours work when they were on call for the obstetrics and gynaecology units.
- Multidisciplinary ward/board rounds took place at 08.30am, 12.30pm, 16.30 and 8.30pm, Monday to Friday.
- Weekend consultant presence was four hours a day. Telephone ward rounds and individual communications occurred throughout the day, night and over the weekend. Specific attendance by consultants was required for full dilatation deliveries in theatre, placenta praevia and twins.
- Between March 2016 and January 2017, the trust reported a medical staffing vacancy rate of 5%, based on 1.23 whole time equivalent vacancies.
- Between March 2016 and January 2017, the trust reported about a turnover rate of 46.6%, based on 10.1 whole time equivalents. We spoke with the management triumvirate about this and were assured that this data appeared to be based on the rotational doctors.
- Between February 2016 and January 2017, the trust reported an average bank and locum use rate of 8.5%. We were told locum staff had a comprehensive induction programme and felt well supported.
- Theatre lists were organised in such a way that there was a woman's hour first thing in the morning. This theatre slot was used to undertake any emergency surgical management of women who had a miscarriage or required minor gynaecological procedures.

Major incident awareness and training

- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.
- The trust had major incident action cards to support the emergency planning and preparedness policy. Staff understood their roles and responsibilities.

Are maternity and gynaecology services well-led?

Good

When we previously inspected the service in March 2016, we rated well-led as 'good.'

At this inspection we also rated well-led as good because:

- There was a cohesive senior management team who were aware of the challenges faced by the service; they had robust plans to sustain and improve the service in the long term.

- There was a defined governance and risk management structure which included a time line for the completion of root cause analysis.
- There was good cross directorate working between maternity and gynaecology.
- There was an open and transparent culture within the organisation. Staff were aware of the duty of candour regulations and could recount occasions where it had been used.
- We observed good working relationships between midwifery, nursing and medical staff. Staff were encouraged to challenge and there was constructive dialogue.
- The service engaged with service users to help shape the future of the maternity and gynaecology service.
- The maternity unit was a pilot site for the new method of midwifery supervision.

Leadership of service

- Maternity and gynaecology services were part of the women and children's directorate. The management triumvirate consisted of a general manager, head of midwifery and a clinical director.
- Leadership was encouraged at all levels within the service. Team leaders were supported to complete the trust leadership programme.
- We observed a strong, cohesive leadership team who understood the challenges for providing good quality care and identified strategies and actions to address these. There was a new structure to ward leadership, which saw the addition of a deputy head of midwifery and a new ward leader on Ward 21 (B18).
- The head of midwifery and deputy head of midwifery were frequently visible in clinical areas and had a good awareness of activity within the service during the inspection. Staff we spoke with informed us the head of midwifery and deputy head of midwifery were seen in uniform and work clinically, if needed. Staff were clear about who their manager was and who members of the senior team were.
- Leadership in the EPAU and GATU was a concern. The service was led by a band seven gynaecology nurse specialist, and staffed by band five nurses. The band seven was not on the unit at all times due to other clinical commitments across the gynaecology department. We were concerned that this well-established team of band five nurses were not familiar with the up to date processes and standard operating procedures. We were told "we just know what to do", these policies and procedures were available on the trust intranet.
- Staff were concerned with the overlap of Triumvirate structures between maternity and gynaecology and surgery, we saw evidence that there were close working relationships between the directorates.

Vision and strategy for this service

- The trust vision of 'right care' was embedded within the service and staff articulated what 'right care' meant for them.
- The trust strategy included maternity and gynaecology services holistically and was women focused; there was no specific strategy for maternity and gynaecology.
- The triumvirate were working towards a two year plan to improve services and provision for women. This included a focus on gynaecology and providing services to other trusts who needed to improve their waiting times.

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure. The trust risk management strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor quality care was reported and improved. The strategy had a maternity specific section; this just explained the role of the supervisors of midwives.
- The labour ward forum and risk management group met monthly and discussed concerns and risks across the service. We reviewed meeting minutes from January to March 2017 and found them to be concise, and included evidence of discussion regarding incidents and root cause analysis. Previous action points were reviewed and monitored.
- The service demonstrated an understanding and addressing of the risks to patient care. The risk management midwife worked proactively within the service and fed into the governance process to recognise and raise concerns and ensure safe practice. For example, staff who were identified to lead RCAs were given a 'timeline' which detailed what actions were required, when and by whom.

- Performance and outcome data was reported and monitored through the regional Yorkshire and Humber regional dashboard. Performance was also discussed at the monthly women's integrated governance group (WIGG). Any outliers (services lying outside the expected range of performance) were reviewed and timely action taken. For example, we found evidence of review and discussion of an increased number of 3rd degree tears and the introduction of a care bundle.
- Local risk registers assisted the WIGG to identify and understand the risks. There were 27 risks identified for maternity and gynaecology: none of the risks were rated above an eight, which was a moderate risk. The register described the risk, existing controls and gaps, and action necessary. For example, for the partial compliance to NICE (QS135) preterm labour and birth guidance, there were existing controls and actions required to reduce the risk. Any risks rated as nine or above were automatically escalated to the trust risk register.
- The service had completed a gap analysis following the publication of the Kirkup report (2015). There were no gaps identified and actions were documented against the recommendations, as necessary.
- The service was a pilot site for the new approach to midwifery supervision called Advocating and Education for Quality Improvement (A-EQUIP). The focus of the pilot had been identified as ward 21 (B18).This involved a small team of midwives and would be a more supportive programme.
- The service had benchmarked themselves against the maternity services review, and action plan had been developed; this had leads allocated and appropriate timescales for completion.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred and use these to learn and improve practice.
- All staff were aware of the duty of candour and were able to give examples of when it had been used.
- We observed team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered.
- Staff told us about the 'open door' policy at directorate level. This meant they could raise a concern or make comments directly with senior management, which demonstrated an open culture within the organisation.
- Staff we spoke with felt supported by the management team during times of heightened activity. They felt supported and worked well together as a team.

Public engagement

- The service actively sought the views of women and their families. The maternity partnership (maternity services liaison committee) met quarterly. We found meetings were focused on improvement and supporting the needs of local service users.
- The service had developed a virtual tour of the unit, including how to access the hospital. There was also information on car safety and screening tests on the website.
- The service used social media, namely Facebook and Twitter, to inform parents of services. There were videos about pelvic floor exercises
- The service was in the process of redesigning community midwifery services; the service was meeting with disadvantaged and hard to reach groups to ensure the service met the local need.

Staff engagement

- Senior managers held lunchtime 'listening' events with staff from children's services. Nurses and healthcare support workers spoke positively about these sessions and told us they felt managers understood their issues and concerns.
- The trust communications team distributed regular bulletins, newsletters and uploaded trust information onto the intranet for staff access.
- Staff told us they were engaged with service development and improvement. They felt they were listened to and supported to suggest service improvements.
- The service had developed a 'Yammer' group (a secure social media platform used within organisations) to share information with staff.

Innovation, improvement and sustainability

- The service had successfully applied to NHS England as part of the maternity safety training fund. The funding was to be used to:

- Increase capacity within ultrasound by training midwife sonographers.
- Provide the accredited New-born Life Support (NLS) training
- Provide human factors training.
- The funding was awarded with assurances from the chief executive that the trust undertakes 13 commitments and the funding is utilised solely for the purpose of maternity safety training.
- The service was implementing an electronic patient record; this would enable a single patient record to be viewed. This would increase patient safety, as all investigations and alerts could be viewed.
- The service was undertaking a service redesign of the community midwifery services, through engagement with staff and patients using an evidence based design approach. Initial outcomes of this work included a single point of contact for women to arrange appointments to go live from May 2017; women would contact community midwives on their work mobiles, which would reduce complaints of delays in returning phone messages at the central office number; the use of social media to engage and inform women and flexible services for example, evening antenatal clinics and consultant clinic being offered in community settings.
- Patients on the EPAU and GATU were asked to provide a password which was used to maintain confidentiality and safety when calling the unit for test results.

Services for children and young people

Safe	Good
Well-led	Good
Overall	

Information about the service

Services for children and young people at Airedale General Hospital included a 24-bed children's ward that provided inpatient and day case care. Four beds were used as an assessment unit for GP referrals, which could also be utilised as overnight beds if required. The neonatal unit had 12 commissioned cots, two of which could provide high dependency or intensive care. Services for children and young people also included a dedicated outpatient department, children's outreach team, community paediatricians, and a child development centre that provided therapy services.

The trust had 5,085 admissions between November 2015 and October 2016; 24.4% of these admissions were children under one year, 26.3% were aged one to three years, 42% aged four to 15 years, and 7.4% were aged 16 to 17 years. For children under one year, the most common reason for admission was acute bronchitis. For those children aged between one and 17 years, the reason was viral infection.

The CQC previously inspected services for children and young people at Airedale General Hospital in March 2016. Services were rated as 'good' overall and in all domains except safe, which required improvement. The inspection team noted staff were caring and compassionate and felt supported by their immediate managers. Inspectors also saw good examples of multidisciplinary teamwork and found staff encouraged children and young people to share their views about the service. However, nurse and medical staffing levels did not meet nationally recommended guidance and the safeguarding supervision system was not robust.

During this visit, we inspected the safe and well-led domains, and reviewed medical and nurse staffing levels as well as escalation and contingency plans in these areas.

We visited the children's ward and outpatient department, the neonatal unit and child development centre. We spoke with 24 members of staff and four families. We reviewed 12 sets of care records, including five prescription charts.

Services for children and young people

Summary of findings

We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection, we reviewed whether the service was safe and well-led. We rated safe and well-led as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Staff had the skills they needed to carry out their role effectively and in line with best practice. Managers were visible and there was a real strength, passion, and resilience across medical and nursing teams to deliver high quality care to children, young people, and their families.
- Since the previous CQC inspection, managers had taken appropriate action to mitigate and manage risk to children and young people by improving medical staffing and by implementing short-term contingency plans on the children's ward.
- Staff told us they were proud to work for the trust and promoted a patient-centred culture. Children, young people and parents felt medical and nursing staff communicated with them effectively, and made them feel felt safe.
- Staff protected children and young people from avoidable harm and abuse, and they followed appropriate processes and procedures to keep them safe. The named nurse for safeguarding children was in the process of establishing a new safeguarding supervision model, to ensure staff shared best practice and lessons learnt from serious incidents and serious case reviews involving children and young people.

Are services for children and young people safe?

Good

We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'requires improvement.' We asked the provider to make improvements following that inspection.

At this inspection, we rated safe as 'good' because:

- Although there were still some nurse staff shortages on the children's ward, managers and senior nurses had taken appropriate steps to mitigate the risk and keep children and young people safe. This included reducing the number of beds from 24 to 20 and utilising paediatric bank and agency nurses. Recruitment was ongoing and managers were confident the ward would return to its full establishment.
- The medical team had a full complement of 10 whole time equivalent consultants, supported by six junior doctors. Consultants provided medical cover on the children's ward and neonatal unit 24 hours a day, seven days a week.
- Staff protected children and young people from avoidable harm and abuse. There were systems and processes to safeguard children and young people. Staff took a proactive approach to safeguarding and focused on early identification. The trust had the appropriate statutory staff in post that were active and engaged in local safeguarding procedures, and worked with other relevant organisations. Staff had also taken appropriate steps to improve the provision of safeguarding supervision.
- On a day-to-day basis, staff assessed, monitored, and managed risks to children and young people and this included risks to children who had complex health needs, or who were receiving end of life care.
- Managers and staff knew their responsibilities for reporting incidents and raising concerns. Staff discussed incidents regularly at ward and governance meetings, and during daily medical and nursing handovers. Staff took appropriate action to prevent incidents from happening again and lessons were learned. When something went wrong, children, young people and families received a sincere apology.

- All areas were visibly clean. Domestic and nursing staff followed cleaning schedules and updated cleaning logs. There were no cases of Clostridium difficile (C.difficile), MRSA, or methicillin sensitive Staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.
- Services for children and young people met the mandatory training requirements most of the time.

However:

- The children's services equipment maintenance assurance log, which recorded inspection due dates, last inspection dates, and repairs, showed 51 outstanding items.

Incidents

- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the risk management reporting system. Medical and nursing staff told us they felt very confident reporting incidents and near misses. Staff felt incidents were escalated appropriately and managers told us staff reported incidents in a timely way.
- There were 247 incidents reported between February 2016 and January 2017 relating to children's services at Airedale General Hospital. Of these, the majority of incidents (79%) did not cause any harm or injuries.
- There were 60 different categories to describe the cause of each incident, which meant, in most cases, only one or two incidents were recorded against each category heading. The majority of incidents (18%) related to staffing levels on the children's ward followed by medication errors, which accounted for 6% of all reported incidents.
- In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SI) in children's services, which met the reporting criteria set by NHS England between January 2016 and December 2016. Both incidents were classed as a diagnostic incident including failure to act on test results.
- We saw evidence of learning from incidents. For example, following a safeguarding incident, managers had strengthened the visiting policy. All of the staff we spoke with knew of the incident and of the new system. We also heard evidence about changes in practice. On the neonatal unit, a preterm baby had sustained a chemical burn from the cleaning solution. An action plan was implemented and clinicians were currently using an alternative product.
- Staff told us they usually received feedback about incidents they had reported. However, managers did not always feedback overarching themes and trends from incidents with frontline staff.
- 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. Between January 2016 and December 2016, the trust reported no incidents which were classified as Never Events for children's' services.
- Staff we spoke with understood the duty of candour requirements. 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. We saw examples demonstrating where staff had followed the procedure in relation to the serious incident investigations, which included interaction with the family.
- The neonatal unit shared learning with colleagues from other trusts, as part of the wider Yorkshire and Humber Neonatal Network, at regional meetings held each quarter. The network aimed to improve outcomes for babies born and cared for across the network region, providing trusts with an opportunity to share good practice.
- Medical and nursing staff discussed paediatric deaths at bi-monthly mortality and morbidity meetings. We reviewed minutes from the last three meetings and noted staff examined recent cases, outcomes, and actions.

Safety Thermometer

- 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 from the Patient

Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no catheter urinary tract infections between January 2016 and January 2017.

- The service had adopted a paediatric scorecard to monitor and measure 'harm free' care. Key performance indicators (KPI) recorded data in relation to the risk of pressure ulcers, fluid balance and feeds, and infection risk. Every month, staff audited the KPIs and overall, compliance levels were consistently good. For example, between January 2016 and March 2017, 100% of patients received a daily assessment of pressure areas, and nurses documented the fluid intake and output in 96% of all cases.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. There were handwashing facilities at the entrance of the children's ward and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within the ward and by each cot in the neonatal unit.
- Infection prevention and control (IPC) was part of the trust's mandatory training programme and the compliance target was 80%. The current compliance rate for nurses and healthcare assistants was 98% and 92% for medical staff. This was an improvement from the previous CQC inspection when compliance was below the required target. Managers told us they were confident all outstanding training would be complete by the end of the current year.
- Children's services recorded no cases of Clostridium difficile (C.diff), methicillin resistant Staphylococcus aureus (MRSA) and methicillin sensitive Staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.
- On the children's ward, the play specialist was responsible for cleaning toys. They told us there was a toy cleaning policy and they cleaned toys daily in line with the documented procedure, however we did not see evidence of a cleaning checklist or records.
- We saw personal protective equipment was readily available to staff to use and we observed staff using it appropriately. We also observed staff adhering to 'bare below the elbow' guidance, in line with national good hygiene practice. Parents we spoke with told us nurses and doctors were 'always washing their hands'.
- Staff regularly took part in IPC audits. Hand hygiene audits showed staff from the children's ward and the neonatal unit achieved consistently good results. In January 2017, the neonatal unit achieved 100% compliance while the children's ward was just below at 95% (although the unit had also achieved 100% in previous months).
- We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance and risks involved in handling of sharps. We observed staff safely disposing of needles in appropriate sharp bins and arranging disposal when full.

Environment and equipment

- Access to the children's ward, neonatal unit and child development centre was restricted. Staff monitored visitors entering and leaving the respective unit and granted access via a secure entry system.
- The children's ward was very child-friendly. It included a large playroom, an outdoor recreation area, and dedicated dining room. There were toys suitable for children of all ages. The unit also included a sensory room used to calm and distract children who have special needs or who may be anxious about treatment.
- At the previous CQC inspection, we recommended the trust reviewed the environment in the Child Development Centre. During this visit, we noted the management team had addressed immediate concerns in relation to urgent repairs. They were fully aware of future requirements and were in the process of reviewing proposals to update the unit. This included ensuring the entrance/reception area complied with the Disability Discrimination Act and was child-friendly.
- In the neonatal unit, the high dependency (HD) bay was located directly behind the nurse station, with a large viewing window to enable an uninterrupted view of the two HD cots at all times. However, there was limited space within the bay and no clinically clean surfaces upon which to place emergency equipment. To mitigate the risk to babies, staff had set up clinical trolleys, specifically for an HD admission. The trolleys were stored in the equipment room, which was located directly across from the HD bay. There was also a non-HD 'holding' cot within the bay, which staff could consider locating elsewhere as this would help increase the amount of space.
- The neonatal unit received additional support from two volunteers from a UK charity that aimed to provide the

best possible neonatal care and support for babies and their families. The volunteers were working with the ward leader to improve the ward environment and equipment. This included reviewing the current facilities for parents.

- We saw evidence of processes to ensure equipment was safe. Staff completed environmental and equipment checks robustly as part of their daily work, and formally through the audit process.
- The children's ward resuscitation trolley held appropriate equipment, which was suitable for the needs of children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. We reviewed the logs and found no omissions.
- There was a new resuscitation trolley in the neonatal unit. Emergency resuscitation equipment had previously been stored in a filing cabinet. The ward leader was working with the trust resuscitation team to finalise and approve a checklist to ensure staff monitored and maintained the equipment appropriately.
- The trust's medical electronics department was responsible for the maintenance of all devices and equipment. Equipment we checked had been safety tested. Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.
- The trust had an equipment maintenance assurance log to record inspection due dates, last inspection dates, and repairs. Information provided to us by the trust showed 51 items due for inspection in October, November and December 2016 were outstanding. It was not clear what action the trust had taken in response to this.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed standard procedures. Medicines were stored in line with the policy, including medicines that required refrigeration.
- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored with access restricted to authorised staff who maintained accurate records.
- Staff performed balance checks regularly in line with the trust policy. We checked medicines and equipment for emergency use and found these were stored securely and a procedure was in place to ensure they were fit for purpose.
- Storage cupboards and fridges were tidy and locked. We saw documentation that demonstrated staff recorded and monitored the minimum and maximum fridge temperature appropriately. Staff also explained the procedure they followed if there was a problem.
- We reviewed five prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature, allergies were documented, medication that was omitted or not administered had a documented reason, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child.

Records

- Medical and nursing staff managed and stored records safely. We did not see any unattended notes or excessive amounts of paediatric records awaiting letters during our inspection.
- We reviewed seven sets of care records. Overall, we saw notes were legible and staff completed them accurately and included appropriate information such as, consent, risk assessments, and nutritional status. There was evidence of consultant review within 14 hours in all cases and, where care was surgical-led, records demonstrated good paediatric oversight. However, in the neonatal notes, we noted some documentation, such as the safety checklist, required updating. The ward leader was aware all of the documentation required a thorough review and planned to create an integrated nursing and clinical care document.
- We saw evidence children and young people had individualised care plans. However, in one case, we noted a staff member had completed a pregnancy test on a young person, without consent and not documented in the care plan. We raised this with the matron who acknowledged there had been an oversight in this case and it should not have happened. The matron told us they planned to talk with the member of staff involved to discuss the issue.
- Nursing key performance indicators (KPIs) included documentation audits. Each month, managers reviewed ten submissions to assess the accuracy of recording and compliance in a number of areas. This included

prescription charts, fluid balance and feeds, nutrition, communication, and pain assessments. We reviewed data from January 2016 to March 2017 and found the results were consistently good.

Safeguarding

- The trust had a safeguarding children policy, which was up to date and due for review in September 2019. Staff we spoke with could explain what actions they would take if they had concerns about a child or young person. Staff recorded safeguarding concerns on a pink form. The notification form was stored in a red file at the nurse's station and a copy placed in the patient's notes. Every day, one of the safeguarding children team visited the ward to review the notes and take appropriate action.
- The named nurse reviewed all of the safeguarding notifications completed by staff, and provided assurance to the trust board through attendance at strategic safeguarding group meetings.
- Medical and nursing staff routinely discussed safeguarding concerns, including children who were subject to a child protection plan, at daily handover meetings on the ward.
- At the previous CQC inspection in March 2016, inspectors noted the system in place for safeguarding supervision was not robust. Managers told us supervision used to be provided on an ad-hoc basis and nurses described the system as informal. The named nurse told us managers had identified safeguarding supervision as a risk on the current trust wide risk register and given priority status. The named nurse was in the process of introducing formal individual and group supervision sessions for all staff. Guidance and procedures were documented within the overarching safeguarding children policy, and were based upon a nationally recognised supervision model.
- Staff told us they felt they received appropriate support and advice from the safeguarding team and the specialist safeguarding nurse was regularly present on the children's ward.
- Consultants participated in monthly peer review meetings, in line with the Royal College of Paediatric and Child Health Intercollegiate (RCPCH) document, Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2014).
- The trust had the necessary statutory staff in post, including the named nurse and named doctor. The director of nursing was the nominated executive lead for safeguarding children and attended Local Safeguarding Children Board meetings. All members of the team attended relevant sub-groups ensuring information and good practice was shared internally and externally. The named nurse described positive working relationships with children's social care services in North and West Yorkshire and Lancashire.
- The trust planned to introduce safeguarding champion roles. A sister from the children's ward and another from critical care had expressed an interest. The named nurse explained staff would receive appropriate training and support.
- The trust set a target of 80% for completion of safeguarding training. Information provided by the trust showed all medical and nursing staff had met the target for all safeguarding children level three and adults' modules. Training included child sexual exploitation, female genital mutilation, domestic abuse and PREVENT, in line with the RCPCH intercollegiate guidance.
- All of the staff we spoke with could describe the learning from safeguarding incidents. In response to a recent incident on the children's ward, the named nurse had developed an action plan and published a new visiting policy with a specific criteria and guidance for staff. Safeguarding leads also produced a quarterly newsletter to share with staff across all services, with current information about safeguarding children and learning from serious case reviews and incidents.
- The safeguarding team were currently developing a work plan for 2017/18 and were in the process of identifying key priorities and safeguarding actions.

Mandatory training

- The trust set a target of 80% for completion of the majority of mandatory training. Mandatory training courses for medical and nursing staff included information governance, fire safety, infection control, health and safety, and basic life support. Compliance was good; however, nursing staff did not meet the required target in two modules: information governance and manual handling people (71% and 51%, respectively). One member of staff told us the manual handling training was tailored towards staff working with adults rather than children and did not meet their needs.

- All of the staff we spoke with told us they had completed all of their mandatory training for the year. Managers told us they expected all staff to have completed mandatory training by the end of the current year and a schedule was planned for the upcoming year.
- Ward leaders acknowledged the difficulty in releasing nursing staff to attend training. One manager told us they were aiming to plan one training day for each member of staff through the e-rostering system.
- Managers told us they received a report every month outlining training requirements for each member of staff. They felt they had good oversight of mandatory training needs and the information was accurate and up to date.

Assessing and responding to patient risk

- The children's ward used the paediatric advanced warning scores (PAWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information, such as the pain score tools, with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with medical staff and nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response.
- Nursing staff audited PAWS charts every month. Overall, staff from the children's ward achieved consistently good results. For example, between January and March 2017, nurses completed PAWS within 10 minutes of admission for every patient and calculated the score correctly. Staff documented the PAWS escalation trigger in 95% of all cases and recorded 98% of PAWS exceptions. However, although staff updated PAWS with each observation, the frequency of those observations was reported as 57%. Senior nurses told us they continued to educate staff regarding PAWS use and were in the process of sourcing new observation charts, with enlarged tables, to promote compliance with the frequency of recording observations.
- Daily nursing and medical handovers took place. They included discussions about patient safety and staff shared detailed information about each child. The meeting highlighted any risks and enabled medical and nursing staff to reinforce plans to monitor deteriorating patients, for example, increasing observations, or nursing care.
- We attended a medical handover meeting and observed consultants, junior doctors and a senior nurse collaboratively discuss and assess the risk of a young patient refusing oral medication before agreeing appropriate action. Clinicians and the ward leader also shared information with non-clinical ward colleagues. For example, we spoke with the housekeeper from the children's ward who told us they received an updated information sheet following each handover meeting with updates about patients with specific needs.
- Clinicians transferred children who required paediatric intensive care to the regional tertiary care hospital. In the event of a child deteriorating and, for example, requiring intubation, staff from the intensive care unit would stabilise the patient with support from a paediatrician (with or without a paediatric nurse). Medical staff would then secure appropriate retrieval or transfer arrangements to the tertiary hospital with the regional retrieval team.
- The trust had a transfer of patient policy (including intra and inter hospital transfers) which included a section for the care and management of paediatric and neonatal patients. The neonatal unit was part of the Yorkshire and Humber Neonatal Network, which provided specific transfer guidelines for the movement of babies who required high dependency or intensive care. This included arrangements for baby retrieval, preparation for transfer, and transport requirements.
- The majority of surgical procedures for children and young people took place on the same day as adult procedures. Surgeons prioritised children on all mixed lists. A pathway outlined a series of actions for staff to follow when referring a child for shared care with the surgical team. Surgeons operated a dedicated child-only list for urology every Wednesday. Standards produced by the Royal College of Anaesthetics state every consultant anaesthetist should perform a minimum of 25 paediatric anaesthesia cases per annum. Information provided by the trust showed this standard was being met.
- There was no separate recovery ward for children post-surgery, which meant children were cared for alongside adults. Staff told us they segregated children from adult patients and the beds were not alongside each other, and nurses provided one-to-one care for each patient. Staff told us there was always someone on shift who had received training in paediatric life support.

- Consultants told us the interface between paediatrics and maternity services was not as robust as it could be. Clinicians explained the teams did not work as closely as they once used to. Although they did not hold joint meetings, paediatricians did attend perinatal mortality and labour ward meetings when appropriate. There was a liaison system in the form of a yellow slip completed by obstetricians and midwives to record information for neonatal staff, such as medication or abnormal scans.
- The neonatal unit did not use a new-born early warning trigger and track (NEWTT) tool, however we noted all babies received frequent observations and checks. Nurses told us they used their own judgement, sought advice from colleagues, and escalated concerns to medical staff when appropriate.

Nursing staffing

- At the previous CQC inspection in March 2016, inspectors found nurse staffing levels did not meet nationally recognised guidance. In the following months, staff told us the children's ward continued to be short-staffed. This created additional pressure for nurses who covered additional shifts through overtime and without the additional support from agency or bank nurses.
- Recent changes in management had introduced significant change on the unit. Senior managers and nurses were taking appropriate action to mitigate risk and ensure staffing levels were safe. For example, the shift nurse in charge reviewed staffing levels every day and managers had recently begun utilising paediatric-trained agency and bank nurses. In addition, there were appropriate escalation procedures. All of the nurses we spoke with told us these changes had a positive impact on the team and the unit. All of the staff we spoke with told us about the improvements in the escalation process.
- Although there were 24 beds, the children's ward was currently operating at 20. Nursing staff told us this was another recent change, but one that had benefited both staff and patients as it ensured there were enough nurses on duty to provide safe care. Managers told us the ward would remain at 20 beds until they had recruited the full establishment of nurses.
- Children's services took into account guidance from the Royal College of Nursing (RCN) in relation to paediatric nurse staffing levels. The RCN standard for bedside deliverable hands-on care recommends one nurse to three children (1:3) under two years of age, and one registered nurse to four children (1:4) over 2 years of age. The ward used an approved tool and template to calculate and record appropriate ratios.
- The ward used the trust e-rostering system and planned for four registered nurses on shift during the day and three registered nurses overnight. Ward staff displayed planned and actual numbers of nurses on a notice board in the ward area.
- We reviewed planned and actual staffing levels on the children's ward. In September 2016, the average fill rate for registered nurses during the day was 96%. This rate dropped to 86% over the next three months. At night, the average fill rate ranged from 98% to 100%.
- Between March 2016 and February 2017, the average occupancy rate on the children's ward during the day was 64% and 52% at night.
- We reviewed staffing rotas in October, November, and December 2016 (one week per month) when the children's ward operated with the full establishment of 24 beds. To compare, we also reviewed one week in February 2017, when the ward bed establishment had reduced to 20. On all four weeks, there were three qualified nurses on every night shift. There were four qualified nurses on all day shifts, with support from one healthcare support worker. Managers confirmed the utilisation of bank nurses meant the ward was able to maintain four qualified nurses each day and meet the appropriate RCN guidance.
- There were 0.66 whole time equivalent (WTE) band six nurse and 4.42 WTE band five nurse vacancies. Senior nurses and managers told us there was a recruitment plan to ensure the unit met its full establishment and were currently recruiting new nursing staff.
- On the neonatal unit, there were 17.49 WTE nurses. Of these, the majority were qualified in specialty (QIS) band six and band seven nurses, which meant there were always two QIS nurse on every shift (exceeding the BAPM recommendation of one QIS per shift). The ward leader planned to introduce 5.6 WTE band five nurses, as part of the succession planning process, to replace band seven nurses who leave through retirement or natural turnover. The ward leader explained the unit would support and develop the band five nurses to enable the unit to sustain its skill mix.
- The neonatal unit took into account guidance from the British Association of Perinatal Medicine (BAPM) in relation to neonatal nurse staffing levels. The BAPM

standard for bedside deliverable hands-on care recommends a staffing ratio of one neonatal nurse to four babies (1:4) in units providing level one special care, and 1:2 for high dependency care.

- We reviewed planned and actual staffing levels on the neonatal unit. From September 2016 to December 2016, the average fill rate for registered nurses during the day was consistently above 98% during the day and 100% at night.
- Between March 2016 and February 2017, the average occupancy rate on the neonatal unit was 61% (day and night). We reviewed staff rotas in March 2017 and noted there was appropriate neonatal nursing cover on all shifts.
- Managers recorded neonatal nurse staffing levels on BadgerNet (a single record of care for all babies within neonatal services, and used widely across the country).The data was replicated onto the trust's acuity tool which enabled managers to view actual staffing levels and patient numbers.
- Only three QIS neonatal nurses had received new born life support (NLS) training. This meant there was not an NLS-trained nurse on every shift. However, nurses had attended simulation training and the ward leader described strong links with the multi-disciplinary team and paediatric anaesthetist lead. Senior managers had identified NLS as a priority and the ward leader confirmed they had secured funding to send all neonatal nurses on the course. QIS nurses would receive training by the end of the current year and all registered nurses by the end of the financial year.
- Nursing staff received bespoke paediatric life support training. The multi-disciplinary Airedale Paediatric Emergency Skills (APES) training was based on the internationally recognised EPLS/APLS courses and clinicians developed the training with support from the Yorkshire Critical Care Network. APES had also received recognition from the Royal College of Anaesthetists. Information provided by the trust showed 42% of registered nurses had completed the training in the last three years. The ward leader explained APES training was ongoing and all nurses would attend.
- The RCN 'Defining Staffing Levels for Children and Young People's Services' (2013) guidelines recommend one member of nursing staff should be supernumerary and external to the nurse rota. The ward leader confirmed the children's ward did not meet this RCN standard as they were part of the main rota.
- A band six nurse led the children's outpatient department, supported by three band five staff nurses and two healthcare support workers (HCSW). The matron explained they hoped to recruit more HCSW to support satellite clinics and improve the skill mix across the service.
- As of February 2017, the average vacancy rate for the service was 5%, based on 3.23 WTE vacancies. The highest vacancy rate was 14%, reported by the children's ward. Between March 2016 and January 2017, the average turnover rate was also 5%.
- Between February 2016 and January 2017, the trust reported no bank or agency usage in children's services. Managers told us they started to introduce the use of bank nurses from February 2017.
- The average sickness rate in 2015/16 was very low at 1%.

Medical staffing

- According to NHS Digital Workforce Statistics, 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 lower than the national average.
- Airedale General Hospital had a full complement of 10 whole time equivalent (WTE) consultants in post and six junior doctors. This demonstrated an improvement since the previous CQC inspection and the consultant rota was currently compliant with the Royal College of Paediatrics and Child Health - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). There was no middle tier of doctor, which meant the neonatal unit did not meet the standards set out in the DH Toolkit for Neonatal Services (2009).
- All clinicians covered both children's ward and the neonatal unit (with a designated lead consultant). We spoke with a junior doctor who told us there should be seven juniors, and the trust was in the process of recruiting a locum doctor to support out of hour shifts.
- There were also four community paediatricians, and the team included the named and designated doctors for safeguarding children.
- Consultants provided on-site cover 24 hours a day, seven days a week with support from a second on-call consultant at home during the night. We reviewed evidence that showed consultants reviewed children and young people within 14 hours of admission. This demonstrated good practice. The team also operated a consultant of the week system.

- Consultants told us they had 10.5 programmed activities per week, although they did not have a specific job plan. Job plans were in the process of production, with only one completed so far.
- Following a recent administration review, the number of medical secretaries providing support to the paediatric consultant team had reduced. Consultants told us this meant they were involved in more administrative tasks themselves and they had formally discussed their concerns with the management team. A senior nurse told us a number of recent incidents, reported by clinicians related to the lack of filing of medical notes. The matron explained there was a plan to create a system to review the current process and take appropriate action to mitigate the risk.
- As of February 2017, the trust reported a vacancy rate of 10% in children's services, which equated to 2.26 WTE. Between February 2016 and January 2017, the trust reported a locum usage rate of 8.3%. The turnover rate during the same period was 54%.
- Between April 2015 and March 2016, the trust reported a sickness rate of 2.3% in children's services.

Major incident awareness and training

- Services for children and young people were part of the trust-wide major incident plan and a departmental paediatric business continuity plan described the steps each area would take in relation to a disruption. A senior nurse told us the plan had recently been activated when the unit experienced a flood.
- Staff we spoke with showed a good awareness of the plans although they were not aware of the frequency of practice and review.

Are services for children and young people well-led?

Good

When we inspected the service in March 2016, we rated well-led as 'good'.

At this inspection, we also rated well-led as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care.
- A triumvirate senior leadership team led the directorate. The service had a good governance and assurance structure, which had patient safety, risk management, and quality measurement at its core. Managers understood the key priorities within the unit and developed proposals and action plans to mitigate risk and manage performance.
- Senior managers had an inspired shared purpose, and strived to deliver. Leadership was good across the service. There was a clear management structure and line managers were visible and involved in the day-to-day running of services. Staff spoke positively about local and senior managers.
- Managers and leaders were visible, and there was a real strength, passion, and resilience within ward based staff to deliver quality care to children, young people, and their families. Staff told us they were proud to work for the trust and promoted a patient-centred culture.
- Staff were positive about working for the trust. They felt respected and valued by managers at all levels and described them as approachable and supportive.

Leadership of service

- Services for children and young people were part of the Women and Children's directorate. A triumvirate leadership team led the directorate and included a general manager, head of midwifery, and two clinical directors (acute and community paediatricians).
- Staff spoke positively about the senior leadership team and the new matron, who was based on the children's ward. Nurses at all levels told us the senior management team provided clear and strong leadership. They demonstrated their understanding of the current issues and the subsequent impact on staff and patients, such as nurse staffing.
- Senior leaders and the director of nursing were visible. Staff told us they chaired lunchtime meetings with staff to listen to concerns, suggestions and to share information. The majority of staff we spoke with attended a session and spoke positively about their experience. All of the staff we spoke with told us senior managers were very proactive and described one of the most positive actions as the recent change in ward management.
- Staff told us they felt supported by their colleagues and ward leaders. They felt there was a clear management structure across the unit. If there was conflict within the service, they would go to their ward leader and seek support.

- Senior managers told us the trust supported and developed leaders through its Right Care new leader's programme. Aimed at leaders throughout the trust, it focused on developing leadership skills for staff with management responsibilities. Other leadership training included coaching skills and staff told us the trust offered a range of appropriate courses.

Vision and strategy for this service

- Although the Women and Children directorate did not have a specific strategy, the senior leadership team were very confident, assured, and clear about the direction of services for children and young people.
- We reviewed the annual plan, which outlined the key strategic service options and service redesign plans for 2017/18 and 2018/19. The plan was aligned with the trust's 'Right Care' strategy and vision, to provide patient centred, quality healthcare services. The children's ward and neonatal unit had also produced ward improvement plans that included key actions to promote improvement.
- The children's unit was in the process of developing its own vision for the future. The matron had arranged a meeting with staff to discuss improvement initiatives, such as workforce developments and a paediatric ambulatory care project.
- Staff we spoke with were clear in their understanding of the overarching trust vision and values. Staff at all levels also understood the priorities of their own service.
- Managers reviewed the progress of the annual plan at regular unit level governance and operational meetings, involving medical, nursing, and managerial staff groups.

Governance, risk management and quality measurement

- The general manager reported directly to the Chief Operating Officer and met monthly with the Chief Operating Officer, Medical Director, Director of Nursing and Director of Finance at the Delivery Assurance Group (DAG), the last of whom chaired the DAG. At this meeting, senior managers discussed emerging risks and key priorities within the service. There were three key governance meetings held across the service. A business meeting where staff discussed service developments, a management meeting focused on finance and human resources, and a clinical governance meeting. We reviewed minutes from recent clinical governance meetings and noted staff discussed issues in relation to incidents and root cause analysis action plans, audit activity, risks, safeguarding children and new guidelines.
- Managers and staff told us the governance process had improved in recent months. Staff described senior managers and leaders as 'open and honest' and the flow of information had improved significantly. Ward meetings took place more regularly and were attended by nurses and clinicians (although staff did acknowledge that meetings were suspended if there were staffing constraints).
- The Women and Children's directorate had a risk register that identified 27 risks, of which four had a risk rating between nine and twelve. The key risks on the register reflected those identified by staff when we asked them about their primary concerns. These included staffing, the increased level of backlog in the paediatric department following the recent administrative review and demand for autism assessment.
- Managers regularly reviewed identified risks at governance meetings in accordance with allocated timeframes. Staff recorded progress made against the risks along with risk controls, gaps in controls and assurance measures within the risk register. There was evidence of re-evaluation of risk grading and on-going review.
- We saw evidence of an on-going programme of internal quality audits and NICE guideline reviews undertaken routinely across children's service to ensure safe and effective care. Medical staff told us the clinical guidelines review system had improved over the last six months. Junior doctors had recently updated all of the neonatal guidelines. Staff told us the majority of those guidelines had been out of date and did not follow current national guidance, such as jaundice guidelines and neonatal sepsis. Managers told us there had been significant improvement and progress.
- Progress and outcomes from audits were monitored through the directorate governance committee and paediatricians and nursing staff also attended monthly audit meetings, chaired by one of the consultants. Learning was shared across the units. For example, a recent PAWS audit identified staff were not recording the frequency of observations on each chart and nurses told us senior staff shared feedback at ward and handover meetings.

- There was evidence of good working relationships with other trusts and organisations across the region, for example, specialist service providers, and neighbouring NHS trusts.
- The neonatal unit worked closely with the Yorkshire and Humber Neonatal Network. The team submitted data from the service to BadgerNet, the network reporting system, which informed quarterly analysis reports about neonatal services across the region.
- Staff told us they were encouraged to report incidents and near misses, concerns from patients and identify risks to the organisation.

Culture within the service

- Staff spoke positively about their role, their team and the care they provided. Some of the comments we heard included 'it's a lovely trust to work for' and 'you can ask anyone anything'. Staff we spoke with recommended the trust as a place to work. Medical and nursing staff reported no bullying, intimidation or harassment behaviour from managers or colleagues.
- We found the ward culture was positive and everyone we spoke with told us the needs of the children and their families were the top priority for the unit.
- Ward based staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children. Staff also told us they felt safe to question and challenge their peers on the ward.
- We spoke with medical and nursing staff who described some staff on the neonatal unit as being resistant to change and not keeping up to date with the latest NICE guidance. The neonatal ward leader and senior leaders were aware of the concerns and had made significant progress in developing new initiatives and promoting staff involvement.
- Staff and managers told us they felt morale across the workforce was improving. A number of nurses had left the service and, anecdotally, staff told us this was due to staffing pressures and a lack of management action. A senior nurse told us they were planning to introduce local exit interviews for those staff working their notice to understand the reasons why they were leaving and what improvements could be made to retain and support current staff.
- Senior leaders had taken robust action to improve the staffing resources and proactively mitigate the risks, which made staff feel more valued and supported. Communication had also improved and staff felt more involved and aware of what was happening across the service.

Public engagement

- Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of caring interactions between staff of all grades with the children and their families.
- Services for children and young people participated in the national Friends and Family Test. Results were consistently positive and recent results showed 98% of families would recommend the children's ward to family and friends. Comment cards were also widely available across the unit. Feedback and actions were shared with children and families via a display board in the ward.
- Staff proactively engaged with young people through the Airedale Hospital Youth Forum. Young people, with support from healthcare staff, primarily led the forum and their aim was to be the voice for children and young people attending the hospital. A recent meeting included a '15 steps challenge'. The group made observations about their initial impressions of the children's ward and outpatients department. The forum shared feedback with managers and key leads from the service, who developed an action plan in response.

Staff engagement

- Senior managers held lunchtime 'listening' events with staff from children's services. Nurses and healthcare support workers spoke positively about these sessions and told us they felt managers understood their issues and concerns.
- Staff told us they participated in the national NHS staff survey however; we were not able to view directorate-specific results.
- Ward leaders were proactive in their efforts to engage with staff and promote involvement in service development. The ward leader from the neonatal unit had established regular ward meetings and told us they had seen the attendance increase each month. Some staff chose to attend even when it was their day off. The matron had also invited all staff to an event to discuss the future vision of services for children and young people, to capture thoughts and ideas from the whole workforce.

- The trust communications team distributed regular bulletins, newsletters and uploaded trust information onto the intranet for staff access.

Innovation, improvement and sustainability

- Managers told us the trust were good at supporting innovative practice and service leaders encouraged their staff to contribute to service development. For example, the matron had planned a meeting with all children's services staff to discuss the future vision of the service.
- Staff spoke positively about the 'Pride of Airedale' award scheme and the accompanying 'Proud' wall displaying photographs of all winners and nominees. Nurses told us this promoted motivation and commitment across the workforce.
- Children's services described good working relationships with local tertiary care centres. Senior nurses and managers maintained strong links with neighbouring hospitals and utilised clinical expertise and advice when appropriate.
- The matron was leading a project to introduce a paediatric ambulatory care function within children's services. The majority of children and young people (60%) were usually discharged home within four to six hours of their stay. The project considered the option of developing a new way of working to promote and sustain early discharge. We reviewed the plan, which formulated ideas in relation to an appropriate environment, equipment, pathways, and staffing.
- The Child Development Centre had recently won an award for helping children who had trouble in communicating with others. The unit had achieved 'Makaton-friendly' status, recognised and endorsed by the Makaton charity itself. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

Outstanding practice and areas for improvement

Outstanding practice

- The Frailty Elderly Pathway Team demonstrated a proactive approach to deal with vulnerable patients to ensure they got the right care as early as possible following hospital arrival. The team had built relationships across the internal multidisciplinary team, with social care colleagues and external care providers. The team have audited their performance and reported successes in admission avoidance, reduced length of stay, less intra-hospital moves, reduction in readmission rates, cost savings and improved patient experience. The team had been nominated for a national award.
- Patients on the EPAU and GATU were asked to provide a password, which was used to maintain confidentiality and safety when calling the unit for test results.

Areas for improvement

Action the hospital MUST take to improve

Urgent and emergency care services

- Ensure that the relevant clinical pathways for children, including for sepsis, are in place.

Medical care services

- Ensure the current capacity and demand issues faced by the Haematology Oncology Day Unit are reviewed and ensure the clinical environment where treatment is provided is fit for purpose in delivering patient care and treatment.
- Ensure safe nurse staffing levels and safe nurse staffing skill mix is maintained across all clinical areas at all times.
- Ensure the 'bleep rota' used to support nurse staffing escalation processes is revisited and ensure all escalation processes are effective in managing nurse staffing issues.
- Ensure all staff follow the standard operating procedure covering the opening and closing of extra capacity beds/wards.
- Ensure all patients received onto the cardiac catheter lab are handed over to a member of staff immediately on arrival and are provided with a mechanism to contact staff in the event of a care need or emergency.

Surgery services

- The trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- The trust must ensure that staff complete their mandatory training including safeguarding training.
- The trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.
- The trust must ensure that the environment of the Dales suite is in line with national guidelines and recommendations.
- Ensure there is a robust, proactive approach to risk assessment and risk management which includes regular review.
- The trust must ensure that patient records are stored securely.

Critical care

- The trust must continue to implement the follow up clinic and rehabilitation after critical illness in line with Guidelines for the Provision of Intensive Care Services 2015 and NICE CG83 Rehabilitation after critical illness.
- The trust must review the process of identifying, recording and reporting mixed sex accommodation occurrences and breaches on ward 16.
- The trust must introduce a robust, proactive approach to risk assessment and risk management which includes regular review.

Action the hospital SHOULD take to improve

Urgent and emergency services

- The trust should ensure that nursing staff receive APLS training to ensure that the department is meeting the intercollegiate standards.

Outstanding practice and areas for improvement

- Continue to recruit nurses of all disciplines but particularly registered children's nurses to ensure that the department meets the Royal College of Nursing guidelines relating to 24 hour cover by a registered children's nurse in the department.
- Continue to ensure that all non-children's nurses attend the APES course to ensure that they have the skills to treat children in emergency situations appropriately.
- Ensure that the department has the appropriate nursing skill mix and ensure that all applicable nurses have undergone triage training.
- Ensure that there is assurance in place that the drugs room temperature does not exceed 25 degrees.

Medical care services

- Ensure learning from submitted incidents is relayed to the incident reporter, relevant staff in the local clinical area and consider initiatives to share lessons learnt to the division and wider trust personnel.
- Ensure patient risks are reassessed and documented in line with local policy and best practice guidelines.
- Consider reviewing the number of incident reporting categories used to promote better data capture and incident analysis into themes and trends.
- Ensure all patients self-medicating on divisional wards are fully assessed as safe to do so in line with local policy.
- Consider a review of the divisional risk register, in particular to revisit the relevance of some historic risks listed and to ensure all current risks are rated according to actual impact on the division and the organisation.
- Consider evaluating some of the staff engagement initiatives to ensure the aims and objectives are effective and are meeting the divisional and trust agenda.
- Ensure clinical waste in the cardiac catheter lab is appropriately stored in a safe area whilst awaiting collection and onward disposal.

Surgery

- Monitor and improve the attendance at governance meetings.
- Ensure all patients self-medicating on the surgical day unit are fully assessed as safe to do so in line with local policy.

Critical care

- Introduce a process to review and share learning from critical care morbidity and mortality.
- Introduce a strategy to obtain and act on patient and public feedback.
- Ensure that staff understand the deprivation of liberty safeguards (DoLs) in order to plan and deliver effective treatment and care.
- Review the capacity and demand on the service and develop a business plan in line with the trust's strategy.
- Continue to deliver care in line with and address the areas where they do not meet the Guidelines for the Provision of Intensive Care Services (2015), for example, nursing staff with a postgraduate qualification and medical staffing.
- Continue to develop the use of competency frameworks and clinical education.

Maternity and gynaecology

- Ensure robust processes are in place to inform staff defective equipment has been reported.
- Ensure community midwives document the named midwife on the antenatal record.
- Work to improve the accuracy of mandatory training data.
- Work to improve the attendance by medical staff at mandatory training.
- Review the leadership structure on early pregnancy unit (EPAU) and gynaecology acute treatment unit (GATU), to ensure there is appropriate accountability and support.

Children and young people's services

- Ensure all equipment is inspected within the required timeframe and ensure there is robust service management oversight of the equipment maintenance assurance log.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment **How the regulation was not being met:** There was no sepsis pathway for children in place. Medicines reconciliation systems and processes to ensure actions from medicines reconciliation were not always acted upon in a timely manner. The application of the five steps to safer surgery, including the WHO checklist, was inconsistent. Within the cardiac catheter lab there was no formal handover between portering and clinical staff to alert of a patient arrival and no arrangements for patients to be able to contact staff whilst waiting.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and Equipment **How the regulation was not being met:** The Haematology Oncology Day Unit (HODU) was small and crowded and there was insufficient space in between patients (and for carers/family members. The environment of the Dales suite did not meet national guidelines and recommendations.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance **How the regulation was not being met:** A review of incidents showed safeguarding policies had not been consistently followed and the recommendations were not comprehensive. On the medical wards, as part of the escalation procedure to support safe staffing, the provider implemented a 'bleep' rota for nurse staffing. The bleep was held by an individual ward based nurse-in-charge without oversight of other clinical areas and with existing ward based clinical and managerial duties, was not effective. Risks were not always identified promptly and adequate action taken to manage them. The environment in the Dales suite had not been identified or addressed. The Standard Operating Procedure for opening and closing escalation beds was not embedded and the ward escalation beds were utilised and decommissioned without full reference to the agreed procedure. The critical care annual plan was not aligned with the trust strategy. There was no evidence of recent review of the critical care risk register in accordance with trust processes. Risk assessments had not been reviewed since 2013. The ward improvement plan had not been updated since September 2016 and did not include recommendations from peer and external reviews. The critical care unit did not have a clear process for identifying and recording and reporting mixed sex accommodation breaches. Care records were no kept securely on surgical wards.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing **How the regulation was not being met:** Staffing levels did not always meet planned levels on medical and surgical wards. Mandatory training compliance was low in surgical services.
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care **How the regulation was not being met:** The rehabilitation service following discharge from hospital did not meet the recommendations of Guidelines for the Provision of Intensive Care Services 2015 (GPICS) or NICE CG83.