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.

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Summary of findings

Overall summary

Airedale General Hospital is an acute hospital, run by Airedale NHS Foundation Trust. It has a total of 395 beds. It provides acute, elective and specialist care for a population of more than 200,000 people from a wide area covering West and North Yorkshire and East Lancashire.

We chose to inspect Airedale General as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. Airedale NHS Foundation Trust was considered to be a low risk provider. Airedale General has been inspected three times by CQC since it was registered in October 2010 and has always been assessed as meeting the standards set out in legislation.

Our inspection team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. The team spent two days visiting the hospital, and conducted a further unannounced visit one week later. We held a public listening event in Keighley and heard directly from 55 people about their experiences of care. We spoke with more than 80 patients and 100 staff. We received valuable information from local bodies such as the clinical commissioning groups, Healthwatch, Health Education England and the medical Royal Colleges.

Our analysis of data from our 'Intelligent Monitoring' system before the visit indicated that the hospital was operating safely and effectively across all key services. The trust's mortality rates were as expected or better than expected across all key areas. When we inspected, we found that services were provided effectively and consistently to a good standard at all times of day.

However, there is no room for complacency. In one medical ward and one surgical ward we were concerned that the current level and mix of staffing could present a risk of patients not receiving safe care. We saw some evidence that this was affecting patients' safety, and it needs to be addressed to reduce the risk.

We also had some concerns about the way the hospital's critical care unit is managed. While the service is safe, effective, caring and responsive, the unit appears to work in isolation from the rest of the hospital. We were not convinced that there is a clear rationale for the way in which the service is organised, and it lacks a clear direction and strategy.

Overall, however, the patients we talked to at Airedale General were very positive about the care they received. Staff told us that they felt proud to work at the hospital. There was a good sense of community, with high levels of volunteering. We recommend the trust's volunteering programme as one that others can learn from. The hospital performs above the national average on the new Friends and Family survey (which asks patients whether they would recommend the hospital to others). The feedback we received from patients and the public throughout the inspection was consistent with this.

The trust is well-managed (although there is room for improvement in the Critical Care Unit, as noted above). The trust benefits from a stable, experienced board and a clear governance structure. This is paying dividends in high levels of staff engagement and patient satisfaction.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Services were generally safe. Staff assessed patients' needs and provided care to meet those needs. There were procedures in place to keep people safe, for example from infections and from preventable falls. Records were maintained to a good standard in most areas. However, staff shortages in wards for older people meant that patients did not always receive care promptly.

Are services effective?

Services were delivered effectively and focused on the needs of patients. Outcomes for patients were mostly as expected or better than expected. All key targets were being met or exceeded.

Are services caring?

The vast majority of people told us about their positive experiences of care. The trust's patient survey scores match the national averages. Patients said that they were satisfied with how they had been treated, and that doctors, nurses and other staff were caring and professional. Staff respected patients' dignity and privacy.

Are services responsive to people's needs?

The services responded to patient's needs. Overall, patients were treated promptly. Complaints and concerns were handled appropriately.

Are services well-led?

The hospital was well-led. The trust Board showed a good understanding of key issues. Individual services were also generally well-led. We had some concerns about leadership within the Critical Care Unit.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency
Accident and emergency provided safe and effective care. The trust was meeting the national target of seeing 95% of patients within four hours of arrival. Staff were caring and responded to patient's needs. The department was well-led. Ninety-one per cent of patients reported that they would recommend the A&E department to their friends or family. Work is planned to improve the A&E buildings and infrastructure by October 2014.

Medical care (including older people's care)
The wards generally provided safe and effective care. We had concerns about staffing levels on one ward for older people. The level and mix of staffing meant there was a risk that patients may not receive safe care. Staff were very busy and, although patients' needs were met, the staff were not always able to attend to patients promptly. The staff on the medical wards were caring and responsive. The wards were well-led.

Surgery
The surgical services were generally safe and effective. We had some concerns about staffing levels on the older people's ward. Some patient records were not fully completed, which could pose a risk to patient care. We found staff were caring and the service responded to patient's needs. The surgical service was well-led. However, mandatory training was not up to date and ward sisters told us it was difficult to access training courses for staff.

Intensive/critical care
Care on the unit was safe and effective. Most patients said that staff were caring and the service responded to patient's needs. We had some concerns that the Critical Care Unit appeared to work in isolation from the rest of the hospital. The inspection team thought that the unit is not organised around the needs of patients.

Maternity and family planning
Maternity care was safe and effective. We had some concerns that healthcare support workers had a large number of different duties, which meant there was a risk that women and babies would not be attended to promptly. The staff were caring and feedback from women was very positive. The service responded to patients' needs and was well-led.

Services for children & young people
Children's care services were safe, effective, caring, responsive to children's needs and well-led.

End of life care
The hospital no longer used the Liverpool Care Pathway for people in the last few days of their lives. However, it did have a guide to essential care for these patients, which was ensuring a safe approach to care.

Summary of findings

Outpatients

The outpatients department provided safe and effective care. Staff were caring and responded to patient's needs. We found that the department was well-led.

Summary of findings

What people who use the trust's services say

- Airedale NHS Foundation Trust scored 56 in the June A&E Friends and Family Test, which was in line with the national average.
- The trust's results in the 2012 adult inpatient survey were also in line with the national picture. However, they did show an improvement on the previous year, apart from patients' views on waiting for a bed on arrival at hospital.
- In the 2011/12 Cancer Patient Experience Survey, Airedale was rated by patients as being in the top 20% of all trusts nationally for 23 out of the 63 questions.

Action the trust COULD take to improve

- Review the nurse staffing levels in wards, particularly those caring for older people, to reflect the dependency of the patients.
- Improve record keeping, particularly in those areas where staffing levels were not always appropriate.
- Improve staff access to, and uptake of, mandatory training. Training is important to ensure that staff have up-to-date skills to provide appropriate care for patients.
- Review the additional duties (such as portering) carried out by staff, particularly healthcare support workers, to avoid compromising patient care.
- Consider how the Critical Care Unit works in step with the rest of the hospital, and review the strategy for the service and the understanding of the standard of service provided.

Good practice

Our inspection team highlighted the following areas of good practice:

- The hospital valued volunteers and they played an important role in helping to run it. For example they helped patients to eat through the Feeding Buddy Scheme, they set up a privacy and dignity room to provide patients with toiletries when they do not have them, and they helped to direct people around the hospital. Volunteers said that their contribution is valued, and they have been given a seat on the Council of Governors.
- The trust has introduced a 'telehealth' hub. Telehealth uses electronic information and communication to provide long-distance healthcare and health-related education.The hub was staffed 24 hours, seven days a week by nurses who specialise in acute care. A consultant was on hand if required. The hub aimed to provide care to patients with long-term conditions, such as respiratory illness. Patients could receive advice and support in their own home, rather than having to go to hospital unnecessarily. The trust also provided this service to prisons across the country.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example details of their current medicine.

Airedale General Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Consultant Oncologist, Royal Berkshire NHS Foundation Trust

Team Leader: Cathy Winn, Care Quality Commission

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers. Experts by experience have personal experience of using or caring for someone who uses this type of service.

The doctors on the team included an executive medical director and junior doctors. The nursing staff included a deputy director of nursing, an executive nurse and chief operating officer, an associate director of nursing (patient safety and governance), a ward matron, a quality improvement manager and a student nurse.

Why we carried out this inspection

We chose to inspect Airedale General as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. Airedale NHS Foundation Trust was considered to be a low risk provider.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection.

Detailed findings

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity
- Children's care
- End of life care
- Outpatients.

The lines of enquiry for this inspection were informed by our Intelligent Monitoring data.

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. We received information from people who use the services, Healthwatch, the medical Royal Colleges, Monitor, Airedale, Wharfedale And Craven Clinical Commissioning Group and Health Education England.

We carried out an announced inspection visit on 19 and 20 September 2013. As part of the inspection we looked at the personal care or treatment records of people who use the service, and we observed how staff cared for patients and talked with people who use the services. We talked with carers and family members.

We held five focus groups with staff. We spoke with and interviewed a range of staff including the Chairman, Chief Executive, Medical Director and Director of Nursing.

We placed five comments boxes around the trust and received comments from people who used the service and staff.

We used the Short Observational Framework for Inspection (SOFI) in one area of the hospital. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.We held a listening event on the evening of 19 September 2013. People were able to talk to us about their experiences and share feedback on how they think the trust needs to improve.

We carried out an unannounced inspection visit on 27 September 2013. As part of the inspection we looked at the personal care and treatment records of people who use the service, observed how people were being cared for and talked with staff and service users.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Services were generally safe. Staff assessed patients' needs and provided care to meet those needs. There were procedures in place to keep people safe, for example from infections and from preventable falls. Records were maintained to a good standard in most areas. However, staff shortages in wards for older people meant that patients did not always receive care promptly.

Our findings

We found that services were safe in accident and emergency, medical care, surgery, intensive/critical care, maternity, children's care, end of life care and outpatients.

Across the areas we inspected, we found that systems were in place to assess patient needs and plan their care. We saw that staff completed documentation appropriately in most cases. We did find that that were some gaps. For example, one person on a surgical ward was diabetic and although their blood sugar levels had been checked, this had not been done consistently. In the patient's care records, there was no plan of care or instructions for staff regarding the person's diabetes care. We spoke to staff who explained how the patient's diabetes was monitored. This showed that safe care was provided, but there had been a risk that this was not the case, as it was not clearly recorded.

People confirmed that they felt safe and at ease with the staff. The majority of comments received from people across the trust were very positive. For example, one person commented, "All staff were very approachable and made me feel at ease. Good explanations were given about what was done and why." This showed patients felt safe and cared for at the hospital.

We found that the trust met people's fundamental care needs. We saw that staff helped people their hygiene needs and that patients received adequate food and drink. There were some examples of good practice, such as the Feeding Buddy Scheme in which volunteers helped patients to eat. This ensured that people got the support they needed when necessary.

The trust managed medicines safely. Patients told us that staff administered their medicines appropriately. For example, one person said that their medication was "carefully dispensed four times each day". We looked at drug charts and found that, in the vast majority of cases, medicines had been recorded as given as prescribed. We saw staff administering controlled drugs in a safe manner. The trust had systems for monitoring the management of medicines and addressing any issues identified.

The trust had access to electronically held information which is held by community services, including GPs. This meant the staff at the hospital could access up-to-date information about patients (for example details of their current medication). This reduced the risk of patients being prescribed incorrect medicines.

Appropriate equipment was available in the hospital, and it was managed adequately. This meant patients were protected against the risks of unsafe or inadequate supply of equipment.

The trust had systems in place for infection control. Infection rates for C. difficile, MRSA and MSSA were satisfactory when compared with rates for other trusts. The trust said that it had been set challenging targets for combatting infection. As part of its assurance processes, the Board received the infection control annual report in July 2013. There was an infection control policy, which was in the process of being reviewed and updated and was accessible to staff on the intranet. The trust had put in place an action plan to reduce the incidence of healthcare associated infections in 2013 and 2014, and we saw evidence that the trust reviewed the plan and monitored progress on a monthly basis. In February 2013, the strategic health authority scrutinised these systems as part of an invited assurance and best practice evaluation and advisory visit.

We reviewed the NHS Staff Survey 2012/13. The trust scored in the bottom 20% of trusts for the percentage of staff who felt satisfied with the quality of work and patient care they were able to deliver.

Staff told us that they felt there was a "high benchmark" for the quality of service at the hospital and they felt they were not always able to give the care they wanted to give. Staffing issues were cited as the main contributory factor.

We looked at whether the hospital had safe staffing levels. Although patient satisfaction with care was generally good,

Are services safe?

staff said that staffing levels were a concern across the hospital. They were particularly concerned about nursing and healthcare support workers, and they said there were not enough doctors on duty at night over the weekend. We found the staffing mix and levels on two wards to be a risk to patient care. We saw that staff were very busy and, although they were meeting patients' needs they were not always able to do so in a timely manner.

The Director of Nursing told us that staffing levels were calculated using nationally recognised guidance and professional judgement. This was based on one nurse per bed in general ward areas and a 65%:35% minimum ratio of registered nurses to healthcare support workers. Specialist areas had a skill mix according to relevant clinical network standards. The Director of Nursing said senior staff were always supported to employ additional staff if required. We saw that this was indeed the case when we visited the wards. However, staff said that requests for additional staff were often made last minute and the additional staff were sometimes not available. Staff were moved from ward to ward and they reported that they felt the hospital ran on goodwill. There were concerns this may not be sustainable long term.

The level of staffing on the wards did not consistently reflect the dependency of the patients we observed. Staffing levels overall were safe and in accordance with agreed staffing establishments. But we found that the size of the wards and the level and mix of staffing meant there was a risk that patients may not receive safe care. This was particularly true for frail older people. There is no definitive national methodology for predicting the number of staff required to provide safe care to an agreed standard, but we found that patient dependency was not explicitly taken into account when calculating staffing levels in general care areas at the hospital. The Director of Nursing said that a review of these areas was underway following a successful bid for further funding.

As part of our unannounced inspection visit, we visited the hospital at the weekend at night and looked at how many doctors were available. We found that the hospital at night team provided a safe level of care. The number of doctors available at night had recently been increased from one to two doctors. This change had been in place for a few weeks prior to our visit and was planned to be in place for a further four months, before being reviewed. Staff reported this had had a positive effect on the availability of medical staff at night. This meant that patient's needs were met in a timely manner by appropriately trained staff.

Systems were in place to monitor and maintain safety, such as the use of a safety thermometer and taped handovers. Making a recording of important information to hand over at the end of a shift meant that staff coming on duty could receive a comprehensive handover from colleagues whilst other staff remained in the ward area with patients. This meant patient safety was maintained.

From 1 April 2010 it became mandatory for NHS trusts in England to report all patient safety incidents.

Our review of the number of incidents reported by Airedale NHS Foundation trust showed that the number of reported incidents was acceptable when compared with other trusts. We found that the trust had systems in place to monitor and review incidents. It had identified that low and no harm incidents accounted for 98.6% of all incidents that had occurred. The trust analysed patient safety data to get an understanding of the issues. It believed that there was a strong culture of reporting incidents at the hospital. Key stakeholders that we consulted during the inspection process confirmed that there was indeed a strong reporting culture.

Over the previous 13 months the trust had been above the national rate for falls in all but three months. It had identified the reduction of slips, trips and falls as a priority, created a Falls Management Steering Group and implemented a policy for the prevention and management of slips, trips and falls. We saw evidence that although the number of reported falls had increased, the number resulting in fracture had reduced. This suggests the actions taken by the trust to minimise the impact of falls has been effective. Systems were in place to monitor falls, and staff recorded data about falls at ward level. We saw an example of a prompt response and initial review by the Assistant Director of Patient Safety after a fall had occurred. A root cause analysis was being arranged to examine causes in more depth. The Ward Manager was involved in the process. This showed that systems were in place to respond appropriately to safety concerns.

The trust's new pressure ulcer rate rose in January 2013, but has remained at a low level since then. The trust had identified the risk of pressure ulcer development as a

Are services safe?

corporate risk and actions were in place to mitigate that risk. Every month, the Board received a report on grade 3/4 (serious) pressure ulcers. Pressure ulcer prevention and management guidelines were in place. The Deputy Director of Nursing reported that that trust had investigated the spike in the new pressure ulcer rate in January 2013 and had concluded that the increase had been in grade 2 pressure ulcers and was exacerbated by a national shortage of pressure-relieving mattresses. We also noted this coincided with a time of increased activity for the trust.

The percentage of patients with a veno-thromboembolism (VTE), including new cases, had been similar to the national rate over the previous 13 months. The trust had changed its processes to include a root cause analysis for reported VTEs. This demonstrates that the trust has systems in place to ensure that it is providing safe care.

The Chief Executive acknowledged that, owing to the age of the hospital (it opened in 1970), the physical environment was not always appropriate. The trust had developed a programme of refurbishment, but this was a long-term process. A new endoscopy suite and maternity-led unit had recently been opened, and refurbishment of A&E services was due to start in October 2013. This meant that the trust was taking reasonable actions to ensure the environment was fit for purpose.

During the course of the inspection, we were informed that somebody had raised a concern about a safeguarding matter. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. In response, the trust followed its policies and procedures. This showed that the trust responded appropriately to safety concerns.

Are services effective?

(for example, treatment is effective)

Summary of findings

Services were delivered effectively and focused on the needs of patients. Outcomes for patients were mostly as expected or better than expected. All key targets were being met or exceeded.

Our findings

Prior to our inspection visit, we reviewed data relating to the effectiveness of the care provided at Airedale General Hospital. This included respiratory conditions and care, stroke care, cardiac conditions, elderly care and the paediatric pathway. The data showed that the care provided at Airedale Hospital was effective for the areas reviewed.

We also examined mortality data. We found that the trust mortality rates, across a range of measures, were similar to or much better than expected for most of the areas. We also found that the care provided at weekends was consistent with the level of care provided during the week in terms of mortality.

During our inspection visit, we looked at the areas where data suggested that mortality rates may be higher than expected. The trust was able to explain the reason for these rates or show that it had already identified the concern and was taking action to investigate and address any potential issues. For example, the Medical Director had raised concerns with the relevant consultants regarding figures for one particular area. This matter had also been escalated through the trust's governance structure. This showed that the trust had effective systems in place to identify and provide assurance that care is effective.

The trust had clear governance structures for assuring good quality and effective treatment and care. It had a fully integrated system that allowed a non-executive director to carry out detailed scrutiny of clinical leaders and their teams regarding specific services. We saw that there was an open and robust process for challenging and improving patient care. However, there was limited evidence that the trust monitored the effectiveness of the Critical Care service.

The trust reported that a consultant-led Mortality Review Group systematically reviews all deaths. This Group had been in place since 2006 and enabled review and learning to take place.

Evidence-based guidelines were available (for example pressure ulcer prevention guidelines), and there was a programme of clinical audits across the trust. This indicated that staff had access to appropriate guidance and that the trust checked this was being used.

The trust invited external review where concerns arose and to provide assurance. For example, Mersey Internal Audit Agency reviewed the Risk Management Strategy in June 2013 and the audit opinion was significant assurance. This demonstrated an openness to examine the effectiveness of systems and to seek assurance that they were effective.

Are services caring?

Summary of findings

The vast majority of people told us about their positive experiences of care. The trust's patient survey scores match the national averages. Patients said that they were satisfied with how they had been treated, and that doctors, nurses and other staff were caring and professional. Staff respected patients' dignity and privacy.

Our findings

During our inspection we held a listening event and left comments cards and boxes around the hospital. The listening event was attended by approximately 55 people, and most told us they had had positive experiences at Airedale General Hospital.

We received 44 completed comments cards. Of these, 38 gave positive comments about the care at the hospital. One person commented, "I have received care always with respect and dignity and been given answers to any questions asked."

We also received information via our website. Most of the feedback was very positive.

The trust had a Patient and Public Engagement and Experience (PPEE) Steering Group, chaired by the Director of Nursing. It aimed to record patients' stories about their experience at the hospital and use them to enhance care and treatment. The Director of Nursing gave these 'patient stories' to the public Board of Directors for consideration.

There was a mix of positive stories and others that required lessons to be learned. The use of a patient story is good practice and is an indication that the Board put the patient at the centre of their work.

The trust had recently introduced Essential Standards of Caring for People with Dignity and Respect (August 2013). This had made staff's responsibilities and trust expectations clear and included processes for monitoring, reporting and learning.

Patients using NHS services are now asked whether they would recommend a hospital to their friends and family if they required similar care or treatment. Airedale General Hospital had performed above the national average on the inpatient test, and was in line with the national rate on the A&E test. This is consistent with the feedback we received form people using the service, via the comments cards and at the listening event.

We reviewed comments about Airedale General Hospital on the NHS Choices website. They highlighted a number of positive and negative areas of performance. The ratings left on the website indicate good performance for staff co-operation and patients being treated with dignity and respect, amongst other things. Concerns were expressed regarding a lack of concern for patients among staff on one ward, long waiting times, and a lack of communication between staff and patients.

The trust had implemented a 'real time' survey to capture patient's views. This was carried out by volunteers. The trust also ran a Patient Panel. This demonstrates it actively sought and listened to patient feedback.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The services responded to patient's needs. Overall, patients were treated promptly. Complaints and concerns were handled appropriately.

Our findings

The trust was hitting the 95% national Accident & Emergency target for the percentage of patients admitted or discharged within the national target time. For most weeks the trust was exceeding the national target. However, there were two weeks in December 2012 and a week in April 2013 when where the trust had a significantly lower percentage of patients being seen within the target time. The trust reported that these coincided with increased attendance at A&E. For example, the number of people attending A&E over winter increased by over 20%.

From December 2012, the trust had no patients waiting between four and 12 hours between the decision to be admitted and being admitted.

The national target is for all patients to be admitted or discharged within four hours of arriving at A&E. Although Airedale was behind the national performance for the first two hours following arrival, it had a lower proportion of patients still waiting in A&E beyond this point than is average for English trusts. This indicates that A&E manages patient flows effectively.

The Department of Health monitors the proportion of cancelled elective operations (operations that are not required because of an emergency). This can be an indication of the management, efficiency and the quality of care within a trust. The number of cancelled operations at Airedale General Hospital was better than expected. This indicates that people who required surgery had their operations and did not have their surgery cancelled.

The way in which a trust handles discharges is an indication of how it responds to patient need. Patients need to be discharged when ready with any information and support provided to ensure the patient does not need to be readmitted into hospital. We looked at the results from the Adult Inpatient Survey and found that the results were consistent with other hospitals. The percentage of people readmitted to hospital unplanned had also been below the national average for a year. We did receive several negative comments about discharge processes. We also noted on one medical ward that people who had been identified as ready for discharge were still in hospital. This indicated that the trust and/or other key stakeholders were not responding promptly to the needs of the patients. This could also impact on the patient flows throughout the hospital and mean that a patient may have to wait in A&E longer as there are no available beds. We noted that the bed occupancy at the hospital overall is lower when compared with other hospitals, but this could become more problematic as bed occupancy increases – particularly over the winter period.

Some patients in England still wait too long for secondary care. We found Airedale NHS Foundation Trust was performing better than the national average for access to secondary care through A&E and from general practice.

The trust had an open approach to dealing with complaints and followed good practice. It sought to learn from complaints and to share learning across the organisation. There were 67 formal (written) complaints in 2012/13. The trust said that this was a decrease on the number of complaints for previous years. One complaint had been upheld by the Parliamentary Health Service Ombudsman. The trust carried out root cause analysis for serious complaints, and it shared the subsequent report with the person who had made the complaint. The trust often offered a face-to-face meeting to people making complaints and involved clinicians to enable learning. The trust recognised that it could still do more to ensure that the whole organisation learns from complaints.

The Patient Advice and Liaison Service (PALS) gave feedback about care and services. In April to June 2013 there were 431 contacts for Airedale General hospital. This included requests for further information, expressions of concern and compliments. It was noted the number of compliments was greater than the number of concerns raised.

The hospital responded well to the cultural, linguistic and religious needs of patients. Translation services were available to service users, and these services were based on individual need. We also noted that Healthwatch (Bradford and district) is working with the trust regarding

Are services responsive to people's needs?

(for example, to feedback?)

improvements within the low vision clinic. There were menus to meet people's specific dietary needs and one person made positive comments about access to prayer facilities at the hospital.

The trust valued volunteers, and they played an important role in the running of the hospital. They helped respond to peoples' needs, for example by helping patients eat through the Feeding Buddy Scheme, setting up a privacy and dignity room to provide patients with toiletries when they do not have them and helping to direct people around the hospital. Volunteers indicated that they feel their contribution is valued, and they have been assigned a seat on the Council of Governors.

During our unannounced visit we observed handover procedures from the day staff to the hospital at night team. This was a multi-professional team that had the full range of skills and competences to respond to and meet the immediate needs of patients at night or out of hours. The team used an electronic system that showed expected admissions and discharges, number of patients waiting in the accident and emergency department, bed capacity and any staffing issues. We observed the use of technology which enabled the night co-ordinator to identify clinical priorities ensuring the hospital at night team could meet the needs of patients.

Doctors said the system was very good, that it reduced inappropriate interruptions by bleeps and increased patient contact time by reducing the amount of time on telephones. They told us the effectiveness of hospital at night cover depended on the co-operation of all clinical specialties and team working. We saw the majority of specialties were represented at the handover with the exception of anaesthetics. We were told that discussions were being held with the clinical director to improve clinical engagement from this area. The system enabled staff to respond promptly to the needs of the patients during the night.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The hospital was well-led. The trust Board showed a good understanding of key issues. Individual services were also generally well-led. We had some concerns about leadership within the Critical Care Unit.

Our findings

The Board had remained stable over the past few years with the Chairman being in post since 2005 and the Chief Executive having been in post since 2010. A stable board is often viewed as an advantage.

We found there was a clear organisational structure in place at the trust. There was also a clear governance and risk management structure.

The Chairman explained that the trust had made changes to risk management in the last year to further develop assurances to the Board and ensure information flows from 'ward to Board.' The Board discusses performance information and commissions a 'deep dive' (detailed examination) where necessary. The Chairman demonstrated that he was open to making further changes and recognised there was more work to be done to consider data which underpins the headline figures. The Chairman was clear about his role, stating it was to run the Board and provide "challenge".

Members of the Board go on a safety walk round once a month. This had recently been extended to include out of hours visits by non-executive directors and Executive Board members. There are systems in place to feed back the findings to the Board. Although some staff were aware of the walk rounds, most staff told us that they were not aware of them. They felt that they did not see Board members as frequently as previously.

Both the Chief Executive and the Chairman stated they had confidence in the managers at the hospital. Senior staff had been supported with 'executive coaching', and the Chief Executive provided examples of how this had benefited individual members of staff. They reported that there was no issue recruiting good staff, although concerns were raised by staff about the allocation and engagement of junior doctors. This was supported by the agency usage figures, which showed medical agency cover had increased. The Chief Executive demonstrated a clear understanding of the issues this raised for the trust and care of patients.

In most of the areas we inspected the services were well led. One patient said, "I'm very impressed … I've only been here since last night and they will have me back home later today … It's well run." We did find that the Intensive/Critical Care Unit appeared to work in isolation from the rest of the hospital and the service it provided felt 'consultant centred' rather than 'patient centred.' There was no clear strategy or vision for the service or understanding about the current standard of service provided. This was the only area of the trust where we had these concerns.

Some staff reported that access to mandatory training was problematic. They said places filled up quickly, training events were often cancelled and staff undertook training in their own time. We reviewed the trust's information on mandatory training and found that this supported what staff had told us. We saw that, for example, around half of staff had not had an update of basic life support or moving and handling. The trust had completed a mandatory training review in May 2013 to increase compliance. It had noted a recent increase in attendance, but this remains an area for improvement. Training is important to ensure staff develop and maintain the skills needed to provide safe and quality care.

Staff generally told us they felt well-supported. They told us that they felt proud to work at the hospital and there was a common feeling of 'ownership' and sense of community. This indicated satisfaction with how the service is led.

In a number of areas, such as maternity and A&E, staff said there was a lack of porters. We were told that a management decision had revised roles and the healthcare support workers had taken on portering duties. We found that on several occasions this impacted on care delivery.

Payment by Results aims to support NHS modernisation by paying hospitals for the work they do, rewarding efficiency and quality. It also carries risks that need to be managed effectively, both locally and nationally. Since 2007, the Audit Commission has delivered an assurance programme for Payment by Results, looking at the quality of clinical coding. Prior to our inspection we identified that the percentage of primary procedures incorrectly recorded was twice the national average. We found a subsequent audit

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

on 16 May 2013 showed the error rate was now below national average. We found staff motivated and knowledgeable. This indicated the service was well led and had responded positively to issues raised.

We saw that the trust was developing plans to manage winter pressures. This is essential to ensure the service is well led through a period where there is likely to be increased numbers of patients requiring care and treatment. The trust had found this particularly challenging last winter.

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Accident and Emergency (A&E) department provides a 24-hour service, seven days a week. It has an annual attendance rate of 55,000 patients. The department has facilities for triage, minor and major injuries. It is led by a Clinical Director, Unit Manager and a Matron.

Summary of findings

Accident and emergency provided safe and effective care. The trust was meeting the national target of seeing 95% of patients within four hours of arrival. Staff were caring and responded to patients' needs. The department was well-led. Ninety-one per cent of patients reported that they would recommend the A&E department to their friends or family. Work is planned to improve the A&E buildings and infrastructure by October 2014.

Accident and emergency

Are accident and emergency services safe?

Patients were assessed promptly after arriving in A&E and could be seen by a doctor quickly if they had urgent needs. Staff had immediate access to clinical information sent by a patient's GP, through the electronic patient records system. Patients told us they had received clinical tests and pain relief in a timely way. One patient said, "I've had blood tests and an x-ray. I've been looked after very well." There were appropriate areas for treating patients with challenging behaviours in a safe environment.

Staff consulted the right colleagues to ensure that patients received the most appropriate support. They reviewed patients' health frequently and regularly and asked specialist doctors and other healthcare professionals to help with assessments and review treatment plans.

Patients with major injuries were seen by an appropriately qualified team and, if necessary, they could be transferred to a specialist unit. The A&E admission form had been revised to include trauma information and ensure that appropriate clinical checks were in place. The Clinical Director told us that all members of the trauma team had received enhanced trauma training, so they were able to manage patients with serious injuries.

The department had systems for managing patients who were at risk of falls. Patient records alerted staff if a patient was at risk, and staff could take action to minimise the risk before the patient was admitted. The Clinical Director told us that the department also worked closely with the Airedale Community Collaborative Care Team to ensure that patients got appropriate fall management support when they returned home.

There was sufficient equipment for resuscitating patients, and staff had been trained how to use it. They said they carried out equipment checks daily and after each use. All staff received cardiopulmonary resuscitation (CPR) training. Where patients required equipment (for example oxygen) during transfer, staff undertaking the transfer had received training in how to use the equipment. This minimised risk to patients during transfer.

There were appropriate processes for safeguarding patients against abuse. The department also had a multidisciplinary Safeguarding Adults and Children Group.

Staff had a good understanding of their roles and responsibilities when reporting safeguarding issues. In accordance with trust policies and procedures, A&E worked closely with other services and agencies in relation to safeguarding issues.

Are accident and emergency services effective?
(for example, treatment is effective)

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies. The department had a number of clinical pathways for care. We looked at the stroke care pathway. A&E staff used an assessment tool to establish the diagnosis of stroke. There were clear processes in place to ensure patients were transferred to the stroke unit within specific timescales. This meant patients received the right care promptly and in the right place.

The department was achieving the national target of seeing 95% of A&E patients within four hours of their arrival. To achieve this, it had developed an Emergency Department and Urgent Care Action Plan, most of which had been put in place. Actions included a Rapid Assessment Team, which involved senior doctors providing faster initial assessments for the most acute patients. Minor injuries opening times had been extended to 11 pm, which had reduced waiting times for initial assessment in the evening and reduced the number of patients being handed over to the night team. Action was being taken to increase the time staff had for direct patient care. This included additional administrative support from the reception team to deal with telephone enquiries at the nurses/doctors station and to assist with ambulance bookings.

In August 2013, 91% of ambulance handovers were within 15 minutes. This was due to improvements to the handover process that had removed the need for ambulance crews to book patients in at reception. The ambulance crew confirmed that there were effective systems in place for transferring the care of a patient to A&E.

The national Friends and Family Test asks patients how likely they are to recommend a hospital after treatment. In Airedale, 91% of patients were extremely likely or likely to recommend the A&E department to friends or family. The trust's score in June 2013 was above the national average.

Accident and emergency

Although the environment of A&E was well managed, it was no longer fit for purpose. The trust has plans for a new A&E unit, which is to be completed by October 2014. The development is intended to create larger working areas to deal with increased activity, and it will have separate treatment areas for children. This would provide safe, accessible surroundings to promote patients' wellbeing.

Are accident and emergency services caring?

Patients spoke positively about the standard of care they had received since arriving at the hospital. They told us they did not have to wait long to be treated. Patients told us, "I was seen within a few minutes by the nurse" "I was seen immediately" and "I'd rather come here as you get seen quicker." They also said that staff had kept them fully informed about their plan of treatment. One patient told us, "I've been told what's going to happen." Patients received information and follow-up advice when they left the department. There were a range of information leaflets, and these were available in different formats and languages. Patients were given information in a format they were able to understand.

Patients and their relatives were treated with privacy and dignity. Staff ensured that the environment allowed privacy so that they could meet the intimate care, treatment and support needs of the patient. Curtains were drawn around each bed and discussions with patients were sufficiently confidential.

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

The department learned from incidents and investigations, and it made appropriate changes. Accidents and incidents were discussed at the monthly clinical governance group. The Clinical Director told us meetings were well attended by medical and nursing staff. Evidence showed learning was shared with staff, which enabled them to reflect and learn from incidents.

There was a process in place to monitor and review complaints and suggestions for improving the service. Complaints were audited, trends identified and action taken, where necessary. For example, a complaint had led to action to improve the review of x-ray misses.

The department was prepared to handle unforeseen major incidents. It had a Major Incident Response Plan, which it had reviewed and updated. It rehearses its response with an annual table top exercise and regular live major incident exercises.

The department has a higher than average rate of patients leaving the department before being seen. However, if a patient left before getting care, a senior doctor would review the patient's treatment plan. If there were any concerns a red alert would be faxed to the patient's GP.

Are accident and emergency services well-led?

We looked at clinical governance arrangements to assess whether there was staff engagement at board level and to determine whether assurance processes were in place to monitor patient safety. We found that there were appropriate clinical governance arrangements to report and manage risk, and there were clear processes for escalating risks to the trust Board, where required. The Clinical Director confirmed that there was good clinical engagement between the department and the Board. Staff said members of the Board had carried out safety walk rounds in the department, and this had included out of hours visits.

The department was well led by the Clinical Director, Unit Manager and Matron. Staff said they had very good leadership, which motivated the team. They told us there was an open culture where they could raise concerns and these would be acted on. Clinical and nursing staff were very dedicated and compassionate. Staff said they were proud to work at the hospital. We observed a strong team spirit and staff told us they worked well as a team.

At times, the department was very busy and staffing levels were stretched. A review showed some imbalance in the staffing levels. The Clinical Director told us that the department had revised consultant rotas so that there would be a consultant in the department until 11 pm. It had also requested extra consultants to support extended

working hours. We were told staff recruitment was continuing and gaps were being filled by locums and resident overnight consultants. Staffing levels were continuously reviewed by the department to ensure patient needs were met.

The department has led effectively to support staff with adequate training. Staff said they had received mandatory training, and there were opportunities for continuing professional development for nurses to enhance their skills. A programme was in place to develop advanced nurse practitioner roles. This would enable nurses to develop advanced skills to assess emergency patients. There were four nurses currently undergoing this training.

There were coaching and development days to enhance team working in the department. The focus of this training was to facilitate new ways of working and to improve clinical effectiveness.

There was evidence of regular teaching sessions for junior doctors. This included weekly teaching and one-to-one teaching with a consultant. Every doctor was supported by a clinical supervisor. Doctors we spoke with confirmed they felt well supported and were able to approach their seniors if they had any concerns. One doctor told us, “It’s a good friendly department. Consultants are very supportive and come in when on call if the department gets busy.”

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The acute medical care services at Airedale Hospital are provided on wards 1, 2, 5, 6, 7, 15 and 19. We visited all these wards during the inspection. Wards 1 and 6 provide care of the frail elderly. Ward 2 is the acute medical unit where patients are predominantly admitted from A&E. The ward also includes an ambulatory care unit. We also visited the stroke unit on ward 5.

Summary of findings

The wards generally provided safe and effective care. We had concerns about staffing levels on one ward for older people. The level and mix of staffing meant there was a risk that patients may not receive safe care. Staff were very busy and, although patients' needs were met, the staff were not always able to attend to patients promptly. The staff on the medical wards were caring and responsive. The wards were well-led.

Medical care (including older people's care)

Are medical care services safe?

Patients' needs were assessed and care was planned to meet those needs, including after discharge from hospital. We saw that medicines were administered safely.

On the wards, staff used a system called 'intentional rounding', which involved making regular checks to ensure that patients were safe and receiving the right care and support. However, on some wards the intentional rounding was only every six hours rather than the typical two hours. This was particularly evident on the frail elderly wards and meant that there was a risk patients may not be monitored to ensure their safety.

To ensure that people living with dementia got the right care and support, services used the Butterfly scheme. Under this scheme, a butterfly symbol informs staff when a patient is living with dementia, so that staff can give an appropriate response. One of the ward managers explained that the butterfly care plans were developed with the help of people's relatives/carers and provided information about people's individual needs and preferences. This helped to make sure that people who may have found it difficult to express their needs received the right care and support during their stay in hospital.

The services had risk assessments, care plans and appropriate monitoring to meet patient's nutritional needs. This included the use of red trays and blue crockery for patients who needed help with their meals, so that staff could identify them. We saw a volunteer, who had been trained as part of the trust's Buddy Feeding Scheme, helping patients to eat. Patients had a choice of food, and there were separate menus for people with special dietary needs (for example a gluten free diet).

Staff followed the trust's policies and procedures for infection prevention and control. We did note some minor issues on some wards, such as no labels on the commodes to show they had been cleaned between use, and there were some unpleasant odours. Staff told us that they discussed infection prevention and control every day in the handover and at the safety brief. This meant that patients, staff and visitors were protected from the risk of cross-infection.

To minimise the risk of falls there were appropriate risk assessments, care plans and equipment such as alarms and high/low beds (beds with adjustable height). Where necessary, services employed extra staff to provide adequate supervision of patients at high risk of falls. A falls dashboard was used to monitor the number of falls and slips in each ward every month. There was an escalation process for reviewing any falls that had resulted in harm. This showed that systems were in place to provide appropriate care to patients at risk of falling. However, the ward environments were cluttered and not designed to make it easy for people with dementia to find their way around. The shortfalls in the environment could potentially increase the risk of patients falling.

Staff assessed patients at the point of admission to find out if they were at risk of developing pressure sores, and there were care plans for those who were at risk. There was a Tissue Viability Nurse Specialist, who supported the ward and monitored and reported on pressure sores throughout the hospital. Staff told us that pressure-relieving equipment was available when needed, and they said they had access to an out-of-hours store room.

People expressed concern over the staffing levels on some of the medical wards. Some said that staff were very busy and this meant that patients sometimes had to wait longer than they should have when they needed help. One relative said, "Last night, I had to wait ages to help him go to the toilet." A patient told us that they felt the ward was understaffed and this meant they often had to wait for help with their basic care needs. Our observations showed that the staff on the ward were under pressure to deliver basic care to people in a timely manner. Although care was safe, staff often only had time to interact with people when they were carrying out specific tasks. This potentially had a negative impact on the experience of patients on this ward.

The acute medical wards used tape recordings for handover, which meant that staff coming to the end of their shift could stay on the ward with patients. This enabled patient safety to be maintained.

Are medical care services effective?
(for example, treatment is effective)

There were systems to help staff provide care that was based on evidence and was clinically effective. Staff said they had access to specialist nurses and gave examples of learning from events, such as attendance at conferences.

Medical care (including older people's care)

The trust had systems for responding to the findings of audits, and staff gave examples of how practices had been changed. For example, the 2012 national stroke improvement audit identified three areas where the trust had not been performing as well as expected. Staff described how action had been taken to address the areas concerned. An external review of stroke services at Airedale General Hospital had been completed in August 2013. The initial findings confirmed action had been taken to address the concerns. This demonstrated the trust had adequate systems in place to provide assurances that the care delivered to patients was effective.

Are medical care services caring?

Staff were kind and patient and took the time to talk to patients and explain what they were doing and why. For example, we observed a healthcare support worker explaining to a patient how their pressure relief mattress worked and why it was necessary. They were very reassuring and explained it would take a little time to get used to.

Staff told us they were proud to work at Airedale and said it was important to them that patients had as good an experience as possible when they were in hospital.

There was information in patients' records which showed they and/or their relatives/carers had been involved in discussions about their care. Patients and relatives told us they were involved and kept informed. One patient said, "It is lovely to involved, spoken to and kept informed," and another said, "I see the doctors every day."

Care was planned and delivered in a way that took account of people's wishes. Staff got verbal consent when helping patients with personal care. They were aware that conversations with patients in the bed bays could easily be overheard by other patients, and they spoke quietly when talking to people about personal or sensitive matters.

Staff were considerate of people's psychological and emotional needs. For example, the team on the stroke ward included a health psychologist to help people adjust to lifestyle changes following a stroke.

Are medical care services responsive to people's needs?

(for example, to feedback?)

We looked at how the trust responded to the cultural, linguistic and religious needs of patients. Interpreter and translator services were available, and staff told us that it was easy to access these services when they were needed. The hospital provided a chapel and a prayer room to support people in meeting their religious needs. We found hearing loops were in use for people who had impaired hearing. Patients had a choice of food and there was a separate 'multi faith' menu to cater for people's individual dietary requirements. This meant staff responded to patient's needs.

There were systems in place for learning from incidents and complaints. Staff gave examples of how they had changed practice as a result of feedback. One example was complaints regarding overnight noise from equipment. In response, the trust had provided patients with ear plugs so that they could get a good night's rest. This demonstrated staff responded to patients' needs and feedback.

The trust had systems and a multidisciplinary team for planning patients' discharge from hospital. However, some staff told us that pressures on staff meant that patient discharges were not always managed as well as they could be. This was particularly true for older people who generally had more complex needs. Our findings supported this with four patients on one ward being 'medically fit' at the time of our inspection. This meant patients were potentially staying in hospital longer than they needed to which could put them at risk. This could also impact on the availability of beds for people waiting to be admitted to hospital.

Are medical care services well-led?

Staff told us how much they enjoyed working at Airedale hospital. Comments such as it is "like a family", "it is a good place to work, I love my job", and we have a "good team" were repeated across the different staff groups.

The matrons and senior nurses told us that the trust had "good leadership" and that they were kept informed through various focus groups and governance meetings. They said they had regular contact with the senior management, the Chief Executive and Board members. They told us that the non-executive Board members

walked around the wards and checked the environment, hygiene and equipment. Other staff groups we spoke with were not as familiar with the Board members and were not aware that they carried out visits to the wards. The majority of staff told us they knew the Chief Executive and the Medical Director.

The senior nursing staff said they believed the trust had a good culture of reporting incidents and concerns. They said they were confident they were listened to and their views were taken into consideration.

The ward managers told us they had regular contact with their matrons and said they felt supported in their roles.

Services had a variety of ways of keeping staff informed. These included daily safety briefings, staff meetings, newsletter and the trusts intranet.

Staff did raise concerns about access to training. Many said they often had to attend training in their own time. They also told us mandatory training did not always take place when it should because of staff shortages.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The surgical care services at Airedale Hospital are provided on wards 9, 10, 13, 14 & 19. Day surgery is provided on ward 20. The hospital provides a range of surgery including orthopaedics, general surgery, urology and gynaecology.

During our inspection we visited four wards and the theatre suite. These included an orthopaedic trauma ward, the surgical assessment unit and the day surgery unit.

Summary of findings

The surgical services were generally safe and effective. We had some concerns about staffing levels on the orthopaedic trauma ward. Some patient records were not fully completed, which could pose a risk to patient care. We found staff were caring and the service responded to patient's needs. The surgical service was well-led. However, mandatory training was not up to date and ward sisters told us it was difficult to access training courses for staff.

Surgery

Are surgery services safe?

Patients' needs had been assessed and care was planned to meet those needs. Patient's clinical records contained nursing and clinical assessments, risk assessments, care plans and mental capacity assessments, where appropriate. On one ward in particular, we found the care records to be exemplary. They were in chronological order, dated and signed, contained accurate nursing assessments, ongoing care needs were identified, and they included clear evidence of discussions regarding care and involvement of patients and relatives.

However, we did find some gaps. For example, on one surgical ward, one person was diabetic and although their blood sugar levels had been checked, this was not done consistently. We looked at the care records and there was no plan of care or instructions for staff regarding the person's diabetes care. Staff explained how the diabetes was monitored. This showed that safe care was provided. However, there was a risk that this may not have been the case, as it was not clearly recorded.

The environment was kept clean as part of the infection control measures. A number of service users commented on the safety and suitability of the premises. One said, "The whole area is kept very clean." Others said they felt their "area, bedding and bed attire was kept 'scrupulously' clean at all times" and that "any spills or mess, and personal care, was carried out and cleaned up quickly without fuss."

There was effective and safe medicines management. Service users on all wards confirmed good practice around giving medication. One said that they got medication "at regular times and checked out using my name and date of birth each time. Staff remained with me until the medication was taken."

The majority of people said that they had not had any slips or accidents on the ward and that staff had assisted them very carefully when they needed any personal care or assistance. They said staff had helped them to become more mobile and had discussed how they could remain safe once back home. However, we observed that the environment provided limited space for patients, and some areas were cluttered. We saw that patients had to navigate obstacles when moving around. This could possibly cause an unnecessary risk to patients.

The department introduced and monitored initiatives to maximise patient safety. We saw data on incidences of medication errors and omissions, pressure ulcers, numbers of patients contracting MRSA and patient falls. This showed that wards were safe. Where incidences had occurred, the department had carried out investigations and risk assessments, and it had updated care plans. The department applied the surgical venous thromboembolism pathway, designed to reduce the incidence of thromboembolisms such as deep vein thrombosis (DVT).

Practices and procedures within theatres were safe. Mortality rates were within normal ranges. This showed care was safe and appropriate checks were in place.

There was a mixed response to food on the wards. One person said, "There was plenty to eat but basic, it was OK and hot or cold drinks were always available." Another said the food was "very nice". Patients confirmed that they had always had enough to eat and that drinks were available. People confirmed staff encouraged them to eat and drink enough according to their care plans.

On one ward, the majority of patients had been diagnosed with dementia. Here, we were told that staff had to be "more firm with some people, particularly at night, when some patients were wanderers". Patients said the staff "worked really hard all the time". One person had an adverse opinion of one ward and said, "It's not very good." Specifically, they were dissatisfied with staffing levels on the ward. They said there were delays in response to the call bell. They also said, "I do know they all work under so much pressure." We visited this ward during the day and at night. We found that the majority of patients had complex needs and there was no indication of how changing dependency levels of patients had been taken into account. This was particularly important for wards where staff were caring for increased numbers of patients with dementia. On one ward, junior doctors felt they were understaffed, although this was not having an effect upon patient care. We concluded that while patient care was safe, there was a risk on some wards that the staff were not always able to attend to patients needs in a timely manner.

Are surgery services effective?
(for example, treatment is effective)

Patients felt that their treatment had been effective at each stage, from addressing their physical and mental

symptoms and distress, to successful surgery and recovery. One person said they had an operation that was carried out successfully, they had only been at the hospital for three days and they were on their feet only 12 hours after the operation was completed. They said they felt very satisfied that their treatment had been "very effective, and it meant a great deal to be able to start moving about more." Another patient said they had developed an aversion to food so were having to be monitored. This showed the care was effective in meeting patient's needs.

We saw that initiatives had been put in place to improve effectiveness of services for patients. These included the Butterfly Scheme for improving services for people with dementia, revised care pathways for procedures such as fractured neck of femur, a single patient record in the day surgery unit, the development of the surgical assessment unit and the introduction of 'intentional care' rounds (planned, regular checks that patients are getting the care they need). These were working well on most wards, but on one ward the effectiveness of the Butterfly Scheme was not clear because patients with diagnosed dementia did not receive additional care relevant to their diagnosis.

The department had weekly multi-disciplinary discharge meetings. Patients confirmed ward rounds were carried out and they had "access to doctors when they needed." This confirmed that effective processes were in place to meet patient's needs.

Are surgery services caring?

We were told that staff were very hard working and were on hand as quickly as possible at all times. People said that they did not have long to wait if staff were helping other patients. They also confirmed that they felt safe and at ease on the ward and that staff were polite and respectful to them, even when at times it was very busy. One person said, "It's been superb, not only here but from the time I was first diagnosed." A few patients did comment that not all staff were caring. For example, one patient said, "Most of the staff are really nice, it's just a few that are not nice … and I do know they all work under so much pressure." Overall, we concluded that patients were treated with care and respect.

There was a positive relationship between staff and patients. A number of patients complimented staff on their ability to explain procedures and post-operative care. One person said that staff had helped them to "understand what the treatment was consisting of, but the doctors also made this very understandable. The modern way that doctors and senior staff talked to patients was so much more respectful than previously and this was really appreciated, including the way these staff, would 'tell you straight'." Another said, "It's all helped me to have no fears, I've had lots of very positive feedback as things have progressed and I'm actually very positive about things." This showed us that patients had an understanding of their care plans. One person said, "Airedale is my local hospital but it will always be my hospital of choice." It was therefore clear that staff addressed the physical, social, psychological and emotional needs of patients where possible.

Patients, families and friends were treated with respect. Patients explained how frontline staff had made a very favourable impression on them. They said they had found nursing and care staff polite and respectful and confirmed that they were keen to ensure their privacy and dignity. For example, one person was able to have private conversations with their family in a private room near the ward. Patients said staff had closed the curtains around their bed area for procedures and personal care.

Are surgery services responsive to people's needs?
(for example, to feedback?)

Staff responded to the needs of patients promptly and appropriately. One person said the hospital had been far more responsive than another hospital they had attended. In particular, the medical team had spoken to them very soon after they arrived at Airedale, and, within a short time they had been operated on, and were now recovering fast in their opinion. People told us medical care was very professional and that doctors were responsive to them as a person and to their needs.

The department encouraged feedback and was responsive to it. It had sought the views of friends and family on their experience within the hospital, and it had used feedback to improve services. There was also a process called 'You said, we did', which enabled people who used services to make suggestions and comments and receive feedback on what the trust had changed and/or improved. This was prominently displayed on all wards.

Surgery

The department had a complaints procedure, and it had responded to all complaints appropriately and in line with trust processes. Staff had discussed outcomes with patients and family members where appropriate. All service users said they were aware of the complaints procedure. Although no-one we spoke to had raised a complaint, they all said they were confident enough to do so if needed.

Staff responded appropriately to individual needs. One person said that the way doctors had responded to them as a family member had been very important. As well as the availability of a private room, the way procedures were explained made them feel fully informed and able to discuss their progress with their partner who was concerned to know progress during visits. The person said that staff made their partner most welcome and this all helped the family. This showed that staff responded appropriately to individual needs.

Are surgery services well-led?

Patients said the overall service was impressive and the hospital seemed to be well run. They said that ward staff worked very well and appeared to communicate with each other and with patients very well.

We saw that there was a management structure in place for the surgical unit. Each ward was led by a ward sister. One ward sister confirmed that a business case had been put to senior management requesting additional staff. She told us that she had not received any feedback from this request, although she was aware it had been discussed. Medical staff said there were concerns about the availability of senior staff to assist throughout the day. However, procedures were in place for the escalation of issues to senior staff including consultants and the medical registrar. This showed that issues could be raised and staff were clear how to do this.

Staff said there was no formal system of supervision practised on the wards, but they were able to speak to their managers at any time and an 'open door' policy existed throughout the hospital. We also checked records of staff training and saw that not all mandatory training was up to date. Ward sisters told us it was difficult to access training courses for staff. Some staff were not up to date with, for example, basic life support, fire safety, safeguarding adults and the Mental Capacity Act. Training is important to ensure staff have up to date skills required to provide effective care for patients. We identified this as an area of improvement for the trust.

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Critical Care Unit had a total of 14 beds, divided into three units: Intensive Care Unit (ICU) had three beds, High Dependency Unit (HDU) had four and the Coronary Care Unit (CCU) had seven beds. The three units, although situated in the same area within the hospital, worked independently of each other.

Summary of findings

Care on the unit was safe and effective. Most patients said that staff were caring and the service responded to patient's needs. We had some concerns that the Critical Care Unit appeared to work in isolation from the rest of the hospital. The inspection team thought that the unit is not organised around the needs of patients.

Intensive/critical care

Are intensive/critical services safe?

People's care needs were assessed and plans were in place to meet those needs. Staff had kept records up to date and had completed daily observation charts. We saw evidence that patients fundamental care needs were met, for example through pressure ulcer prevention and management. Throughout the visit we observed staff caring for people on the unit in a timely manner. This showed that patient care was delivered as planned to meet patient's needs.

Appropriate equipment was available to deliver care safely. The Matron in ITU is a member of the trust medical devices committee and managed the equipment for the hospital. The system was well run and organised.

The environment limited the implementation of safe practice in relation to infection control. There was no side room available in ITU to isolate patients who pose an infection risk to others. Staff told us that such patients were nursed at the end of the ward and were separated by a curtain. There was a risk that effective infection control would not be maintained.

There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas provided a balanced skill mix and allocation of staff. There was always a senior nurse identified as the lead for the unit, 24 hours per day. Where there were unexpected absences, systems were in place to address any staffing shortfalls.

The three units were situated in the same area within the hospital, but they worked independently of each other. The anaesthetic consultants were responsible for the patients in ITU. There was one anaesthetist with a special interest in ITU care. On ITU the consultants covered the rota for a day at a time. There did not appear to be a clinical rationale for this approach. The clinical lead for critical care agreed that it was out of keeping with how most other ITU units now provide their consultant cover. This means that there was a risk to the continuity for patient care.

The patients in HDU beds were looked after by whichever medical consultant the patient was admitted under. This meant that every patient in the department could potentially have a different consultant looking after them. There was no routine input from the critical care team.

The CCU was supervised by the cardiology team who saw the patients daily. Due to the nature of the cardiology service that is provided at this hospital, the patients in the CCU are usually low risk, awaiting transfer to a larger unit. The care provided was safe.

Services had systems and processes for reporting and recording adverse events. There were systems to ensure monitoring at a local and trust-wide level. We saw that the outcomes from a local investigation following two recent events were recorded and managed appropriately. We saw that staff handovers were used to share any learning.

There was limited space available for storing equipment, which meant the corridor areas within the unit were generally cluttered and posed a potential hazard.

There was no security system in place on the entrance doors to the unit. This means people could freely access the unit. This could pose a safety risk.

Are intensive/critical services effective? (for example, treatment is effective)

The trust submitted the required data to the Intensive Care National Audit and Research Centre (ICNARC), which aims to foster improvements in the organisation and practice of critical care (intensive and high dependency care) in the UK. This information had been submitted since April 2012 and we were told that plans were in place to review the previous 12 months' data. There were no previous reviews of the data and the trust was unable to provide us with a recent report. The review of the data is important to monitor the effectiveness of the unit and allow comparison with other intensive care units nationally.

We found limited evidence that the trust monitored the effectiveness of the services. For example, infection control information was not publicly available and the Matron did not have information readily available. Staff appeared to rely on trust-level data rather than service-specific information, for example regarding mortality. It is important to monitor the effectiveness of the service to identify any trends and issues at an early stage.

Senior nursing and medical staff told us that the overall bed availability across the trust often resulted in people staying in the unit longer than planned or required. On occasions, people using the services were discharged home directly from the unit. The pathway of care was

Intensive/critical care

therefore not as planned for some patients. This finding was not consistent with the bed occupancy rates, which indicated beds should have usually been available. While this may not have a detrimental effect on an individual's care, it is potentially not an effective use of the critical care facilities.

Are intensive/critical services caring?

Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs, and 'do not enter' signs were attached to drawn curtains. This demonstrated that staff acted appropriately to maintain patients' privacy.

Most patients were aware of their care and treatment. Most described their clinical care as very good or excellent, but they were less praising of staff's compassionate care. One person told us that the staff always gave them information when they asked questions. Another told us that they were waiting for a diagnostic procedure, that they were unsure of the procedure but had been given an information leaflet to read. However, another patient told us that staff told them what to do, and one patient described their care to us as "cold and clinical." This indicated that some patients had experiences that did not demonstrate compassion or a caring approach.

During our inspection we noted that the alarms on equipment were constantly sounding. We did not see staff attending to them. The noise was not conducive to a caring environment.

Are intensive/critical services responsive to people's needs?
(for example, to feedback?)

The hospital had an acute medical team which was led by a consultant nurse. The team provided a service 24 hours a day, 7 days a week. Its remit included bed management and dealing with people who develop early warning scores triggers. It also responded by reviewing patients who staff were concerned about.

During our unannounced visit we observed the team providing support to staff during the night shift. This demonstrated that systems were in place so staff could respond appropriately to patient's needs, particularly for patients whose condition was deteriorating. However, the service was not supported by any critical care specialists and worked entirely independently from the unit. This could impact on the effectiveness of the service.

The trust had developed formal networks and arrangements with other NHS trust regional centres. For example, care for people who required specialist services (for example for major trauma, severe neurological head injuries or conditions that were deteriorating) were transferred via these networks to the regional centres. Arrangements were in place to return patients to Airedale General hospital once they were fit enough to transfer. This showed that systems were in place to respond to patient's needs.

Are intensive/critical services well-led?

The critical care unit appeared to work in isolation from the rest of the hospital and the service it provided felt 'consultant centred' rather than 'patient centred'. There were no admission criteria for patients on the HDU and there were very high levels of bed occupancy. This meant there was a risk of inconsistency in the use of HDU beds and access for patients.

The trust described medical leadership and accountability as being three separate specialist medical teams (ITU, HDU and CCU) working within one unit. However, what remained unclear were the benefits of having the three separate specialities operating in this way. There was no clear strategy or vision for the service or understanding about the current standard of service provided. There was a risk that care was not effective or efficient, due to the lack of clear direction.

Nursing leadership and accountability was clearly defined. Staff rotas identified a senior lead co-ordinator for each shift. Nurse to patient staffing ratios were in accordance with nationally accepted guidance for specialist areas. This ensured there were enough suitably skilled nurses to provide patient care.

Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Maternity services at Airedale care for around 2,500 women and their families every year and cover a large area across West and North Yorkshire and East Lancashire. The unit compromises of an antenatal clinic, early pregnancy unit, maternity assessment centre, labour ward, Airedale birth centre, maternity (antenatal/postnatal) ward (ward 21) and a neonatal unit.

During our inspection we visited the antenatal/postnatal ward, labour ward and the neonatal unit.

Summary of findings

Maternity care was safe and effective. We had some concerns that healthcare support workers had a large number of different duties, which meant there was a risk that women and babies would not be attended to promptly. The staff were caring and feedback from women was very positive. The service responded to patients' needs and was well-led.

Maternity and family planning

Are maternity and family planning services safe?

Maternity services monitored risk effectively and minimised risk for patients and service users. The department had a local risk register, which was monitored and managed by the Maternity Integrated Governance Group. The Head of Midwifery told us there were currently no high-risk items on the register.

Equipment was available to meet women's needs. Staff told us that the department always received the equipment it needed from the hospital equipment programme. The Head of Midwifery said that the department would develop a business case for larger items of equipment that may be needed to improve the service.

Arrangements were in place to ensure a sufficient number of staff to provide safe care. The department had the standard ratio of one midwife to 28 patient hospital births. This was an improvement on figures from earlier in the year. The Head of Midwifery explained that a recent reconfiguration of maternity services had meant changes to staffing levels in some clinical areas. For example, on the antenatal / post natal ward (ward 21) bed numbers had been reduced to 15 and there were fewer midwives on duty. The Head of Midwifery said that the department was confident that the maternity services clinical areas were correctly staffed in relation to their workloads.

Staff were aware of why services had been reconfigured and why staff numbers had changed in some areas. They thought that the reduction in staff on duty had lowered morale. The majority felt that staffing was "too tight" at busier times on ward 21 and the labour ward. For example, one person said they were often "stretched when busy or something unexpected" occurred. The Head of Midwifery and Matron for Maternity Services told us staff could escalate concerns and get additional help during busy periods. Not all staff were aware of this process. To ensure that safe staffing levels are maintained to meet women's needs, it is important that staff are made aware that they can get additional help during busy periods.

A number of staff raised concerns that the HCSW role was broad and that HCSWs were sometimes taken away from direct patient care because they had to act in a 'portering' role. For example, HCSWs acted as 'runners' in the labour ward theatre suite, and on ward 21 they took patients to and from the ward. We observed two occasions where the lack of access to a porter meant delays to patient care. On the labour ward, a patient was waiting to come down to the induction suite but was delayed by approximately 30 minutes because nobody was available to bring the patient to the suite from ward 21. While we were on ward 21, theatre called to request a patient bed. The HCSW was busy providing breastfeeding support, and so there was a delay before the bed could be moved. Midwifery staff of all grades stressed how valuable HCSWs were to patient care, stating that they were a key part of the staffing establishment. Staff also said that recent changes in staffing levels put HCSWs under further pressure. We discussed the use of HCSWs with the Head of Midwifery, who said they would review this matter.

Overall, we found that there were sufficient numbers of suitably skilled staff to meet patient needs. However, the varied duties of the HCSW (including portering duties) meant there was a risk that women's needs would not be met in a timely manner.

Are maternity and family planning services effective?
(for example, treatment is effective)

Maternity services review guidance to ensure clinical practice is evidence based. Maternity services have an Integrated Governance Group, which is chaired by the clinical lead for the service along with staff representatives. The Group reviews guidance and current clinical guidelines. The Head of Midwifery outlined how the group functioned and how it would review new national guidance. The process would involve a gap analysis to determine what improvements would be gained in comparison with current practice. If the Group did not adopt a specific guideline it would carry out a risk assessment and feed back to the appropriate hospital committee. The Matron of Maternity Services outlined how guidelines had been previously reviewed. The Head of Midwifery explained that the hospital had a lead for NICE guidelines, who worked closely other hospital departments.

The department regularly reviewed care to identify how clinical practice could be improved for patients. A consultant obstetrician explained that there was a weekly review of women's case notes held on the labour ward.

Maternity and family planning

Notes were reviewed to look at what happened for specific cases, so that learning could be shared where those members of staff attending felt a particular case could have been handled differently. The department also held peri-natal mortality meetings twice a month to review quality of care.

Processes were in place to record, investigate and learn from incidents within maternity services. The department followed the hospital's incident reporting processes. We were informed that incidents were reviewed and discussed within the Maternity Integrated Governance Group. The Head of Midwifery talked through a recent incident that was in the process of investigation and explained how a previous serious untoward incident had led to changes in practice. Some staff told us they received feedback from incidents via ward meetings.

Are maternity and family planning services caring?

The department sought people's views in various ways. We were told that it completed a 'real time survey' every day and that the hospital had also taken part in national maternity surveys. The Head of Midwifery explained that women were able to complete feedback cards and the department had previously held focus groups. This demonstrated a commitment to finding out if services met women's needs and on how caring services were.

Maternity care records showed that women's antenatal, labour and post natal needs had been assessed according to their individual needs. For example, the antenatal handheld record had included appropriate assessments, checks and discussion of various milestones that may occur during pregnancy.

We witnessed staff maintaining patients' privacy and dignity. Staff had professional, pleasant interactions with patients while offering open discussion and support. They answered the nurse call buzzers promptly so that patients' needs were met immediately. This demonstrated respect and an ability to provide services in a caring manner.

Patients were positive about their overall experiences, for example praising communication, highlighting how they had felt supported, and how they had been kept well informed. One expectant mother mentioned "really accessible staff … quick response to my queries … it was important that my toddler was included in appointments and that staff related to the whole family." Others said, "care has exceeded my expectations", "my family was welcomed and encouraged to stay" and "cannot believe how well I have been cared for." This demonstrated that compassionate care had been provided.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

The trust has systems in place to meet people's religious and cultural needs. Staff explained how they could access interpreters when required. Staff had access to a range of information leaflets in different languages. This indicated that staff responded appropriately to women's individual needs.

The department had systems for managing patients with complications safely and effectively. For example, babies born at 26 weeks or less or with certain complications would be transferred from the hospital's neonatal unit to the regional neonatal centre in Leeds. The baby would be transferred via the 'EMBRACE' network, which is a specialist transport service for critically ill children in Yorkshire and the Humber.

Are maternity and family planning services well-led?

Maternity services had clearly defined leadership roles. The Senior Sisters of both the labour ward and ward 21 reported to the Matron for Maternity Services. The Matron reported directly to the Head of Midwifery, who also had a dual role as the General Manager for Children's Services. The management team said that they felt well supported and that they were kept well informed by their line managers, with whom they had regular meetings. The department had a weekly business meeting to discuss matters arising for the maternity and paediatric services. This showed that the service was well led.

The Maternity Integrated Governance Group monitored ongoing quality and delivery of maternity services. Staff on the labour ward and ward 21 explained ward meetings were held to keep staff informed of developments, both within maternity services and the hospital. One of the

consultant obstetricians stated that they "felt listened to … [and new] developments were given attention when indicated." Most staff showed awareness of hospital-level communication such as the team briefs. One member of staff thought organisational communication was poor at times and stated that the hospitals "executive team were not particularly visible" on the clinical areas. This showed communication systems were in place but staff did not always feel these were effective.

Staff received appropriate support to develop and maintain the requisite skills to provide safe and effective care. The Head of Midwifery explained current 'supervisor of midwives' roles worked to a ratio of one supervisor to 14 midwives, which was within an accepted range. The Senior Sister of ward 21 told us that supervision worked well and was supportive. This view was supported by a staff midwife, who explained that they had received good support from their direct supervisor and there was "generally great team working." All grades of staff felt they were part of a close working team with a "real community feel." All the staff we talked with told us they received an annual appraisal and that they had accessed the hospital's mandatory training programme.

Services for children & young people

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The paediatric team at Airedale provides inpatient paediatric services, including services for newly born children. There is a neo-natal unit with 15 cots. The children's unit is a 24 bedded facility, covering both day cases and acute admissions. Paediatric services at Airedale Hospital had 24-hour access to a resident consultant paediatrician.

Summary of findings

Children's care services were safe, effective, caring, responsive to children's needs and well-led.

Services for children & young people

Are services for children & young people safe?

Paediatric services monitored and minimised risks effectively. The department maintained a local risk register, and the Matron and the Senior Sister explained how it was used to manage two examples of risks (winter admission pressures and the use of a disinfectant as a skin preparation for babies on the neonatal unit). The local risk register was monitored and managed by the Paediatric Risk Management Group and the Paediatric Governance Group. The Matron went on to explain how safety alerts were received and actioned, where applicable, to the service.There were effective systems for identifying and learning from incidents. This is important for promoting safety. The department followed the hospital's incident reporting processes. The Matron and Senior Sister told us that staff within the service were "very good" at reporting incidents. We were informed that all incidents were reviewed and discussed within the Paediatric Risk Management Group. The Matron told us that staff received written feedback about incidents that had occurred within the service so that learning could take place. We were told that one-to-one meetings could be held to support individual members of staff, where necessary, so that they learned from a particular incident. Staff confirmed they received feedback about reported incidents.

Equipment was available to meet children's needs. The Matron explained that paediatric services always received the equipment they needed from the hospitals equipment replacement programme. Staff we spoke with told us they always had access to equipment they needed to meet patients' needs.

The Matron explained that the department worked closely with the hospital's Infection Prevention Team. This close working had enabled the service to make slight modifications to some of the provider-wide risk assessment tools to ensure they met the needs of children. Patient's care records showed that various individualised risk assessments had been completed on admission. Each child had undergone a formalised risk assessment relating to the risk of developing pressure sores. This particular assessment does not always occur within all hospital paediatric settings and is good practice. This demonstrated appropriate risk assessments were in place to maintain children's safety.

There were adequate numbers of appropriately skilled staff on duty on the children's ward and neonatal unit. For example, the Senior Sister on the neonatal unit confirmed that over 70% of registered nurses had completed a recognised neonatal course, as required by best practice guidance for staffing these areas. Staffing levels were adjusted when required. For example, the number of registered nurses on duty was increased during the winter months because of increased admissions.

The Matron explained a senior nurse was on duty for every shift so that staff were adequately supported and well led. Staff said they thought there were enough staff on duty to meet children's needs. Patients and their families told us that staff attended to their needs promptly. We confirmed that junior doctor cover was available for paediatric services, and we found that the paediatric services at Airedale Hospital had 24-hour access to a consultant paediatrician. The consultant resided on the neonatal unit out of usual weekday hours but was available for all clinical areas where children may attend. This does not occur in all district general hospital settings and should be regarded as good practice. These arrangements ensured that children had access to appropriately skilled professionals at all times.

Are services for children & young people effective?
(for example, treatment is effective)

The Paediatric Governance Group is chaired by the clinical lead for the service and has staff representatives. The Matron explained how the Group functioned and how it reviewed the work produced by other paediatric groups such as the Risk Group. The Paediatric Governance Group completed an annual report, which reviewed areas such as completed audit findings, research and new clinical guidelines which had been developed and introduced. The service also has a specific Paediatric Guidelines Group, which exists to review new national/best practice guidance and develop new local clinical guidance. This group has involved all grades of staff. For example, a staff nurse would have reviewed the new clinical guidelines. The Matron and Senior Sister explained that this group included a parent representative who would review the clinical guideline and

Services for children & young people

provide comments for feedback into the group. The existence of these groups showed that the department reviews guidance to ensure clinical practice is evidence based.

Are services for children & young people caring?

The department gave service users a voice in various decision-making groups. For example, the Matron said that there was a parent representative on the Paediatric Information Group, Paediatric Guidelines Group and the Paediatric trust Fund Committee. We were told that the hospital organised a youth panel, which had visited the ward during 2012 and suggested areas for improvement, which had been implemented. For example, changes had been made to meal choices, and toileting packs had been made available for teenagers.

Staff and services met patients' physical, social, psychological and emotional needs. The Matron explained how services used a recognised model of nursing (Casey's partnership model) to ensure that they provided family-centred care. Nursing care records showed that staff had assessed children and families according to their individual need. They had also used a range of risk assessments so that children could be kept safe. Parents and children told us they were happy with the care and information they had received. One young person explained how he had felt fully informed about the various investigations he had undergone and stated, "The nurses are great!" Another parent said, "Staff are brilliant!"

People felt well cared for and fully involved in their child's care planning, treatment and discharge. One parent told us how discharge planning had started at the beginning of their stay, and they were able to provide examples of the types of arrangements that had been made once the family returned home. This parent explained how they had been fully supported, kept well informed and kept fully involved in all aspects of their child's stay.

Are services for children & young people responsive to people's needs? (for example, to feedback?)

The trust has systems in place to meet people's religious and cultural needs. We talked with two parents and one young person from an ethnic minority background who told us they thought the staff had met their personal and cultural needs. This indicated that staff responded appropriately to children's individual needs.

The children's ward and neonatal unit use a system developed regionally for hospitals that send critically ill children to the 'paediatric intensive care unit' (PICU) in Leeds. The system, known as the 'paediatric advanced warning score' (PAWS), was based around five age related colour coded observation charts and guidelines. These charts allowed the paediatrician and children's nursing team to promptly identify when a child's clinical observations may be lying outside the normal range. The colour codes on the charts then assisted the decision-making processes regarding the stabilisation and transfer of critically ill children to a regional PICU using a range of clinical guidelines. The Matron and Senior Sister explained the introduction of the PAWS "really valuable" in the early identification of critically ill children allowing prompt transfer. We saw a local audit which had been produced which had demonstrated improved outcomes for children regarding their emergency transfer to the regional centre. This showed that the service responded appropriately to the needs of children whose condition was deteriorating.The hospital is part of the 'EMBRACE' network which is a specialist transport service for critically ill children in Yorkshire and the Humber. The Matron and sisters from the children's ward and neonatal unit to told us access to this service usually worked very well. We observed the arrival of a return transfer via EMBRACE during our visit to the neonatal unit. Both clinical areas had contingency arrangements for when the EMBRACE service was not available. The matron explained this would involve the use of the second on-call consultant paediatrician escorting the critically ill child in an emergency ambulance. This process demonstrated that the hospital had safe and effective systems in place to ensure a critically ill child can be promptly identified and transferred to a regional specialist paediatric centre.

Services for children & young people

Both Senior Sisters from the children's ward and the neonatal unit explained they had positive working relationships with various other departments within the hospital. For example, the Senior Sister on the neonatal unit explained they attended the maternity services 'Labour Ward Forum', which included 'paediatrics' as a standing agenda item. This allowed each department to ensure closer integrated working to ensure positive outcomes for users of the service.

Are services for children & young people well-led?

Paediatric services had clearly defined leadership roles. The Senior Sisters of both the paediatric ward and the neonatal unit reported to the Matron for Children's Services. The Matron reported directly to the Head of Midwifery, who also had a dual role as the General Manager for Children's Services. The management team said that they felt well supported and that they were kept well informed by their line managers, with whom they had regular meetings. The department had a weekly business meeting to discuss matters arising for the maternity and paediatric services. This showed that the service was well led.

The department held a range of meetings to review and monitor the effectiveness of paediatric services. The Matron explained how the various forums, such as the Paediatric Risk Group, fed into the Paediatric Governance Group. Any matters arising that required escalation for wider discussion would go forward to the combined maternity/paediatric business meeting or appropriate hospital-wide group. Staff told us regular ward meetings were held, and they felt that they were kept informed and involved about decisions relating to the service. Staff were positive about "good team working" and one children's nurse stated it's a "really warm place to work." This showed communication systems were in place to ensure staff were engaged and issues could be raised.

The management team support staff in developing the appropriate skills to meet the needs of families and children. Staff said they received an annual appraisal and had access to the hospitals mandatory training programme. The Matron explained that the paediatric services operated its own paediatric training week so that child-focused training could be delivered (on skills such as children's safeguarding and child resuscitation). Staff said they were supported with additional learning and practice development.

The Matron for Children's Services explained that safeguarding children's roles were clearly defined within the hospital. The Matron was the 'named nurse' for safeguarding children. The Director of Nursing was the nominated executive lead for safeguarding. The hospital's Annual report for safeguarding children and adults within Airedale NHS Foundation trust April 2012–March 2013 set out how there were robust safeguarding arrangements in place for children and young people. This included an emphasis on ensuring all members of staff within the hospital maintained awareness on recognising individuals at risk of abuse.

End of life care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The trust has a dedicated palliative care team led by two specialist consultants. Palliative care is provided across the hospital. The service is provided five days a week. Out of hours support is available via a 24 hour helpline to the local hospice.

Summary of findings

The hospital no longer used the Liverpool Care Pathway for people in the last few days of their lives. However, it did have a guide to essential care for these patients, which was ensuring a safe approach to care.

End of life care

Are end of life care services safe?

There were no patients on the end of life pathway when we visited. We reviewed a 'spot check' that was completed when the report of the Liverpool Care Pathway was published. The spot check has been conducted by the palliative care consultant, and we found that it had been thorough. This demonstrated that appropriate decisions had been made.

The trust no longer used the Liverpool Care Pathway. However, it did have a guide to essential care for patients in the last few days of life. This showed that the trust had responded to concerns regarding implementation of the Liverpool Care Pathway and ensuring a safe approach to care.

Are end of life care services effective?
(for example, treatment is effective)

The Senior Palliative Nurse told us that the end of life (EoL) service was a trust priority. The trust had in place a multi-professional/multi-agency group for end of life, and reporting structures and processes were in place. Systems were in place to steer and redesign patient pathways in conjunction with partner organisations and patient representative groups. This demonstrated that the trust had systems in place to ensure the end of life care pathways were effective.

The EoL team focused on ensuring high-quality services that meet the needs of the people who used the service and their families. This team also worked in partnership with other specialist palliative care teams from the local hospices and other community agencies across the Bradford and Airedale district to ensure effective delivery of the service.

The trust was providing end of life care effectively and it had systems to ensure care was monitored and continuously developed. It had action plans in place to identify and monitor people's care against their EoL work plans, risk registers and against the 16 National Institute for Health and Clinical Excellence (NICE) quality standards. The work plans and statements included the patient experience, pathways of care, personalised care and provision of specialist trained staff and advisors. The trust had assessed itself against the NICE quality standards.

There were no areas of concern. We saw actions had been developed to improve EoL care for people who used the service. Systems were in place to ensure these plans were reviewed and monitored by the trust.

Are end of life care services caring?

We spoke with one person using the service and they told us that they couldn't praise the staff more. They said that "the palliative care nurse was amazing and they couldn't have been more helpful". They mentioned the timeliness of pain relief, which had meant that the previous night they had the best night's sleep for weeks. They also told us that all of their questions had been answered and they had been treated with care and compassion. They were fully involved with their care and they were aware of their prognosis and what the next steps were and who to contact in the community after they were discharged.

We also received comments through our website from people receiving EoL care. Most told us they had had positive experiences. People told us: "I have been involved all the way through"; "the decision was made by me"; and "best in West Yorkshire." Another patient described their care as follows: "10 out of 10 for us. The sensitivity and care for us is unbelievably good; they keep us informed all the time and if we are not sure we ask and they come. Doctors see us all the time." This showed that patients experienced caring and compassionate care.

Are end of life care services responsive to people's needs?
(for example, to feedback?)

The palliative team aims to see people, as a minimum, within two days of receiving the initial referral. We looked at two people's care records and saw that these people were seen on the same day the referral was received. The team also attended a number of the ward rounds where people were receiving end of life care. This showed that the team was responsive to the needs of patients.

The Senior Palliative Nurse told us that in response to the national independent review of the Liverpool Care Pathway published in July 2013, the Department of Health asked all acute trusts to undertake an immediate clinical review of

End of life care

everybody who was on the Pathway. We saw a copy of the trust's clinical review, completed in July 2013, and saw that people being cared for at the end of their life were receiving a high standard of care.

We visited the mortuary as part of our inspection. We found the staff and facilities were sufficient for the trust to be able to respond to people's needs.

Decisions regarding resuscitation were subject to review by the trust. It had recently undertaken an audit which identified areas for improvement. This included improving the documentation of the conversations with the patient and family. This was consistent with findings during the inspection. The trust had processes in place to monitor and ensure improvement in the issues identified.

Are end of life care services well-led?

The trust's dedicated Palliative Care Team consisted of two Specialist Consultants in Palliative Care and two Senior Nurses.

The Senior Palliative Nurse told us that the EoL service was a trust priority. The trust had in place a multi-professional/ multi-agency group for end of life and reporting structures and processes were in place. Staff were confident that they were listened to, and they felt able to voice any concerns or aspirations to improve the department. This demonstrated effective leadership.

The trust had produced a new pathway to guide and support staff in caring for people in the last few days of their life during the six months period when the Liverpool Care Pathway is being phased out. Senior ward nurses confirmed that they were aware of this new pathway and guidance in the absence of a nationally agreed pathway. This demonstrated that the service was well-led.

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The hospital runs a range of outpatient clinics. Around 150,000 outpatients are seen at the hospital each year.

Summary of findings

The outpatients department provided safe and effective care. Staff were caring and responded to patient's needs. We found that the department was well-led.

Outpatients

Are outpatients services safe?

Patients received effective, safe and appropriate care. Treatment reflected their needs, preferences and diversity. The analysis of diagnostic tests and assessments were undertaken by qualified staff and advice was sought from other healthcare professionals, where necessary.

To protect patients from abuse, there were safeguarding leads for adults and children. Staff were aware of how to identify, report and respond to suspected or actual abuse. Where restraint was required for patients with challenging behaviours, there were suitable arrangements in place to ensure the use of restraint was lawful and justifiable. This ensured that attempts to reduce challenging behaviour or restrain a patient respected their dignity and protected their human rights.

The outpatient areas were clean and well maintained. There were infection control measures in place. Staff were aware of their responsibilities in infection prevention and control. This ensured patients were protected from the risk of infection.

Are outpatients services effective? (for example, treatment is effective)

We looked at clinical governance arrangements to assess whether there was staff engagement from board level and assurance processes were in place to monitor patient safety. We found there were appropriate systems in place for the reporting and management of risk. There were clear processes for escalating risks to the trust Board where required.

The department was able to learn from incidents and investigations and to make appropriate changes. Accidents and incidents were discussed and staff used 'suggestion cards' to raise concerns and share good practice. This ensures lessons can be learned to improve patients' experience.

Are outpatients services caring?

Patients were complimentary about the care and treatment they had received. They told us they had been seen within their appointment times. One patient told us, "I get a text to remind me when my appointment is." Another patient in the ophthalmology clinic said, "It's sometimes very busy, but today has been good. I've only waited 30 minutes."

Patients were given enough information before and after operations to help them make decisions about their treatment. Information included the risks, benefits and alternative treatment options. Patients told us that they received information in a way they were able to understand. Leaflets were available in different formats for people who were partially sighted or who required information in language other than English. There was also an interpreting service. Patients said they were given enough time to think about their consent decisions before having treatment. One patient told us, "I was fully informed before and after my operation. It's all been very good. If I had any questions staff were very helpful." This showed staff cared about meeting patients' individual needs.

Staff had the appropriate skills and knowledge to seek consent from patients. This ensured patients were able to make an informed choice. Where patients did not have the capacity to consent, staff undertook an assessment of their understanding. This was in accordance with the legal requirements of the Mental Capacity Act 2005. Where decisions about care and treatment had to be made, this was done in the best interests of the patient.

Arrangements were in place for seeking and obtaining consent from children. Staff were aware of respecting confidentiality where this was requested by a child who was competent to make their own decisions. Where a child was unable to give consent, there were processes to identify who had parental responsibility.

Staff respected patient's privacy and dignity. Clinic doors were closed during clinical examinations. Where any intimate personal care and support was being given by a member of the opposite sex, the patient was offered the option of a chaperone. The chaperone was a healthcare professional of, wherever possible, the same sex as the patient receiving care. This showed that patient's religious and cultural beliefs were being considered.

The reception staff provided clear information and advice. Patients were advised about follow-up appointments, and

transport could be arranged if required. There were also volunteer guides available in the department to support patients and guide them to the correct clinics. This demonstrated the service was patient-focused.

Are outpatients services responsive to people's needs?
(for example, to feedback?)

Staff informed us about the Butterfly Scheme, which uses a butterfly symbol to identify patients with dementia and help staff to respond appropriately. The department had appointed butterfly champions, and staff had received training in dementia care. A system was in place to allow patients with dementia to bypass queues at outpatient reception. This showed the service responded to individual's needs.

We were shown the telehealth hub. Telehealth uses electronic information and telecommunications technologies to provide long-distance healthcare and professional health-related education.The hub was staffed 24 hours, seven days a week by skilled nurses who specialised in acute care, and a consultant was on hand if required. The hub aimed to provide care to patients with long term conditions such as diabetes and respiratory illness who did not want to spend time in hospital unnecessarily. This enabled patients to receive advice and support in their own home.

Are outpatients services well-led?

The clinical and nursing staff were very dedicated and compassionate. We observed a strong team spirit and staff told us they worked well as a team. They said there was a flexible workforce and staff covered shifts on other hospital sites if required. There were rotas in place for each clinic to ensure the appropriate skill mix of staff who were providing care. We found there were no issues between clinical teams and the department was well led.

Staff said they had very good leadership and managers were proactive and visible in the department. They told us there was an 'open culture' where they could raise concerns about safety issues and these would be acted on.

Staff confirmed they were up to date with mandatory training and had planned dates for their annual appraisal. There were opportunities for continuing professional development. This ensured patients received care from staff who were properly trained and supervised.

Good practice and areas for improvement

Introduction

Airedale General Hospital is valued by the people who use the services and the staff who work there. The vast majority of people were satisfied with the care provided. We found there were some areas for improvement such as staffing, compliance with mandatory training and leadership in critical care. The trust had positive engagement with volunteers who were an integral part of the team.

Areas of good practice

Our inspection team highlighted the following areas of good practice:

- The hospital valued volunteers and they played an important role in helping to run it. For example they helped patients to eat through the Feeding Buddy Scheme, they set up a privacy and dignity room to provide patients with toiletries when they do not have them, and they helped to direct people around the hospital. Volunteers said that their contribution is valued, and they have been given a seat on the Council of Governors.
- The trust has introduced a 'telehealth' hub. Telehealth uses electronic information and communication to provide long-distance healthcare and health-related education.The hub was staffed 24 hours, seven days a week by nurses who specialise in acute care. A consultant was on hand if required. The hub aimed to provide care to patients with long-term conditions, such as respiratory illness. Patients could receive advice and support in their own home, rather than having to go to hospital unnecessarily. The trust also provided this service to prisons across the country.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example details of their current medicine.

Areas in need of improvement

Action the hospital COULD take to improve

- Review the nurse staffing levels in wards, particularly those caring for older people, to reflect the dependency of the patients.
- Improve record keeping, particularly in those areas where staffing levels were not always appropriate.
- Improve staff access to, and uptake of, mandatory training. Training is important to ensure that staff have up-to-date skills to provide appropriate care for patients.
- Review the additional duties (such as portering) carried out staff, particularly healthcare support workers, to avoid compromising patient care.
- Consider how the Critical Care Unit works in step with the rest of the hospital, and review the strategy for the service and the understanding of the standard of service provided.