Airedale NHS Foundation Trust

Quality Report

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Date of inspection visit: 15-18, 31 March and 11 May 2016
Date of publication: 10/08/2016

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Airedale NHS Foundation Trust from 15 -18 March 2016 and undertook an unannounced inspection on 31 March 2016 and 11 May 2016. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme. We previously inspected Airedale General Hospital in September 2013. This was part of our pilot for the comprehensive programme. The hospital was not rated at that time.

We included the following locations as part of this inspection:

- Airedale General Hospital
- Community services including adult community services, community inpatients and end of life care.

Following our inspection in March 2016, the Trust informed us of a serious incident that had occurred on the critical care unit at Airedale General Hospital. On further analysis of other evidence, we undertook a further unannounced focussed inspection on 11 May 2016. The focus of the inspection was staffing levels, training and competency of staff, equipment checks and patient care within the critical care unit.

We rated Airedale General Hospital as requires improvement. We rated caring, effective and responsive as good. Safe and well-led were rated as requires improvement.

We rated emergency and urgent care, maternity and gynaecology, services for children and young people, end of life care and outpatients and diagnostics as good. We rated critical care, medical care and surgery as requires improvement.

Within the community services, we rated adult community services, community inpatients and end of life care as good. We rated well-led for adult community services as outstanding.

Our key findings were as follows:

- The trust was inspected in September 2013 and our inspection report at the time demonstrated good quality of services generally with some concerns relating to critical care in particular.Our inspection of March 2016 showed that whilst the majority of services were good, the trust requires improvement and we have seen deterioration in some services namely critical care, surgery and medicine.
- Most staff reported a positive culture and we found that staff were caring and treated patients and their families with dignity. However, we saw evidence that there were areas of the trust that whilst staff reported feeling proud to work at Airedale, some staff described a less open and positive culture.We had some concern over leadership and the relationship with and management of staff, particularly in critical care.
- Nurse staffing levels in many clinical areas within Airedale General Hospital were regularly below the planned number. This was a particular concern in critical care, medical care, surgery and children's services. Planned nurse staffing levels in critical care were below the levels recommended in national guidance.
- Medical staffing numbers did not meet national guidance in the emergency department and there were insufficient intensivists in critical care. We saw the trust were committed to further recruitment of ED consultants and had five intensivists employed.
- We found a culture of continual service improvement and innovation in adult community services. There were several examples of enhanced integration between health and social care within community services for adults.
- The management of medicines required improvement in several areas across the hospital.
- We had concerns about the escalation process of deteriorating patients particularly with medical care and surgery; systems used were not always effective.
- We found governance systems and processes were not always effective and, in some areas within Airedale General Hospital. Risks were not always identified and where these were, there was not always sufficient assurance in place.

Summary of findings

- Mandatory training compliance did not meet the trust's target of 80% in several areas including medical care and surgery. This was monitored within business groups, at the Mandatory Training Group and at the Executive Assurance Group.
- We found the hospital was clean and observed that most staff adhered to infection control principles. Between March 2015 and March 2016 there were three incidents of MRSA at the trust. Incidents of MSSA and Clostridium difficile had been mainly in line with the England average.
- Mortality indicators showed no evidence of risk.
- We found that patients were assessed and supported with food and drink to meet their nutritional needs.
- A new emergency department had been opened to meet the increase in patient numbers and new models of working.
- The trust had a 'Right Care' vision. The majority of staff understood the vision.Directorate plans were in place which supported the trust's vision and strategy.
- Following our inspection in March 2016, the Trust informed us of a serious incident that had occurred on the critical care unit. A further unannounced inspection showed insufficient action had been taken to prevent recurrence. Consequently, we spoke with the Chief Executive to gain assurance that additional actions were taken to ensure safety.

We saw several areas of outstanding practice including:

- Telemedicine services provided at the digital care hub were outstanding. The telemedicine service provided remote video consultations between Airedale staff and patients in their own homes, care homes and in prisons. Clinical staff in the hub received calls from staff in care homes and could speak to residents directly whilst viewing them on the screen. They provided advice and support on the most appropriate action to take. If necessary, they could call for emergency services on the patient's behalf whilst continuing to give advice and reassurance. This service was available 24 hours a day 365 days a year.
- The community-based collaborative care teams were an outstanding example of a multidisciplinary team working. The teams worked across acute and community services and in collaboration with other agencies to provide a responsive service for patients 24 hours a day, 7 days a week. The teams aimed to support patients in crisis to remain in their own homes and avoid unnecessary hospital admission as well as supporting early discharge from hospital.
- Within end of life care, there were innovative ways to ensure care was patient centred for example the Gold Line Service, and 'flags' on electronic records; when patients with additional needs were admitted at the end of life, specialist staff were alerted and could respond in a timely way.
- Through the use of an electronic record and an integration system, a shared record could be accessed securely by partners across all the care settings to obtain a tailored view of an individual's information.

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

Importantly, the trust must:

- The trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- The trust must ensure that the remote telemetry monitoring of patients is safe and effective.
- The trust must review the governance arrangements and management of risks within critical care to ensure that arrangements for assessing, monitoring and improving the quality and safety of the service are effective.
- The trust must review the effectiveness of controls and actions on the local and corporate risk register, particularly in medical care and children and young people's services.
- The trust must continue to improve engagement with staff and respond appropriately to concerns raised by staff.
- The trust must ensure that staff complete their mandatory training including safeguarding training.

Summary of findings

- The trust must ensure that guidelines are up to date and meet national recommendations within NICE guidance or guidance from similar bodies.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must ensure the safe storage and administrations of medicines.
- The trust must improve compliance in medicines reconciliation.
- The trust must ensure records are stored and completed in line with professional standards, including an individualised care plan.
- The trust must ensure an effective system is in place to ensure that community paediatric letters are produced and communicated in a timely manner.
- The trust must ensure that resuscitation and emergency equipment including neonatal resuscitaires, is checked on a daily basis in line with trust guidelines.
- The trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.
- The trust must ensure that were the responsibility for surgical patients is transferred to another person, the care of these patients is effectively communicated.
- The trust must ensure there are sufficient numbers of intensivists deployed in accordance with national guidance.
- The unit must ensure a minimum of 50% of nursing staff have a post registration qualifications in critical care.
- A multi-disciplinary clinical ward round within Intensive Care must take place every day, in accordance with national guidance, to share information and carry out timely interventions.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Airedale NHS Foundation Trust

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

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

There were approximately 358 beds at this trust including 317 general and acute care, 27 maternity and 14 critical care beds.

The catchment area of Airedale NHS Foundation Trust includes people in Craven and Pendle district councils as well as from Bradford and Leeds unitary authorities. Pendle district and Bradford UA are both in the most deprived quartile of local authorities nationally, Leeds UA is in the second quartile while Craven district is the least deprived and in the fourth quartile nationally.

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

We carried out the inspection as part of the Care Quality Commission comprehensive inspection programme. We previously inspected Airedale General Hospital in September 2013. This was part of our pilot for the comprehensive programme. A report was produced and published. The hospital was not rated at that time.

Our inspection team

Our inspection team was led by:

Chair: Jan Filochowski

Head of Hospital Inspections: Julie Walton

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, community nurses, therapists, nurse directors and expert by experience.

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 inspected the following eight core services at Airedale General Hospital:

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

Summary of findings

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community inpatient services at Castleberg Hospital

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held stalls at Airedale General Hospital on 8 and 9 March 2016 and provided comment cards and boxes at a number of locations across the organisation. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who contributed.

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

What people who use the trust's services say

The trust's Friends and Family Test performance has been better than the England average since April 2015. In November 2015, the trust performance was 96.7% compared to a national average of 95.7%.

The national inpatient survey from 2015 showed the results for Airedale NHS Foundation Trust were about the same as other trusts. The national maternity survey from 2015 showed the results Airedale NHS Foundation Trust were better when compared to other trusts for labour and birth and about the same for staff during labour and birth and care in hospital after birth.

Facts and data about this trust

The trust 2,317 whole time equivalents (WTE) staff against a planned number of 2440.8 WTE at 30 November 2015. This included 241 WTE medical and dental and 1,386 WTE nursing and midwifery staff.

Between January 2015 and December 2015, there were 53,746 emergency department attendances and 27,108 inpatient admissions. Of the inpatient admissions, 542 were elective, 15,180 were day case and 11,386 were emergency admissions. There were 153,079 outpatient attendances of which 27,554 were first attendances and 71,497 were follow up attendances.

The trust has an annual turnover of £154 million, and in 2014/15 it had a deficit of £2.8 million. The deficit was reported to be due to a change to the Modern Equivalent Assets valuation, therefore the position excluding this was a surplus of £59k for the year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safe as requires improvement because: • There were shortages of staff across many areas including critical care, medicine, surgery and paediatrics. There was a shortage of intensivists in critical care. • There was a lack of escalation of potentially deteriorating patients, in line with the guidance, for one third of the charts reviewed in medicine. • The critical care unit used telemetry equipment to monitor the heart rhythm of patients on wards remotely and send information to a screen in the unit. However, critical care staff were not always available to monitor the data and respond in a timely manner. • Level 2 and 3 adult and Level 3 children's safeguarding training compliance was below the trust target of 80%. • We had some concerns about the response to incidents particularly within critical care. However we also found: • Most staff were aware of the Duty of Candour requirements and there was evidence the duty had been applied. • Effective safeguarding processes were in place. **Duty of Candour** • The trust was aware of its obligations in relation to the Duty of Candour requirements. The legal Duty of Candour requires the trust to disclose openly events that have led to moderate, major or catastrophic harm to a patient. • The trust had identified the Assistant Director Healthcare Governance as the lead person responsible for the Duty of Candour implementation. • The trust's Serious Incident Policy and Being Open policy incorporated guidance for staff on implementation of the duty. • There were systems in place to monitor the adherence to the duty through the trust's Quality and Safety Team. • The trust's online incident reporting form included prompts for the Duty of Candour at three steps of the process. • Different levels of training had been provided to staff. An overview of the key steps to the duty of candour was provided	**Requires improvement** 

at mandatory training for all staff, lead investigator training included the principles of the duty of candour and there was also a specialist session on the duty of candour available for staff.

- We found that most staff were aware of the Duty of Candour requirements and could explain the principles of being open and transparent with patients, families and carers. Awareness of Duty of Candour requirements was less evident in the community settings.
- During the inspection, we reviewed six serious incident investigation reports and saw that Duty of Candour had been applied.

Safeguarding

- The trust had children's and adult's safeguarding policies in place and were in the process of updating these. The safeguarding team had recognised that assurance of compliance with the policy could be improved and the new policy included undertaking 'snapshot' audits. The updated policy was subject to consultation at the time of inspection.
- There was a named doctor and named nurse for safeguarding children, named midwife and a named nurse for safeguarding adults, as required.
- We found the trust had achieved its 80% target for Level 1 children's and adult safeguarding training with compliance rates at 85% and 89% respectively. Level 2 safeguarding children training for all clinical staff was at 79% at the time of inspection.
- However, Level 2 and 3 adult and Level 3 children's safeguarding training compliance was below the trust target of 80%. Ten out of the 35 (28.6%) staff requiring Level 2 and 3 adult safeguarding training were compliant. The trust was waiting for more external training places to be made available. All staff that were out of hours site managers and all staff that were part of the on-call rota were receiving PROTECT training.
- Approximately 65% of those requiring Level 3 children's safeguarding training had undertaken the training.The safeguarding team also reported that 80% (four) of those requiring Level four were compliant, with one member of staff needing to submit their evidence to support their training.
- The executive lead for safeguarding both adults and children was the Director of Nursing.The Deputy Director for Patient Safety had operational responsibility for safeguarding.
- There was a trust-wide adults and children's strategic safeguarding group, which included community staff, chaired by the Director of Nursing. This was supported by operational

safeguarding groups for children, adults and the emergency department. The adults and children's strategic safeguarding group reported to the Quality and Safety Operational Group, a sub-committee of the board.

- The trust covered three local authorities. The trust had ensured representation on the Bradford Safeguarding Children's Board, Safeguarding Children's and Safeguarding Adult's Health Partnership groups for North Yorkshire and had systems in place to ensure information from the Lancashire Safeguarding Children Board was received.
- The trust had completed the self-assessment audit tool from the children's safeguarding boards and identified some areas for improvement, for example, training in recruitment practices.
- The trust had an action plan in place in response to the Savile Inquiry and we saw that most of the actions had been implemented; there were plans in place where actions had not yet been fully achieved.

Incidents

- The trust reported 36 serious incidents between February 2015 and January 2016. There were no never events reported.
- NRLS data for Aug 2014 to July 2015 (extracted 31 Oct 2015) showed the trust reported less incidents per 100 admissions than the national average. The incident reporting rate was 7 per 100 admissions compared to the England average of 8.6. Of these, 98% of these were categorised as low or no harm.
- Adverse incidents were reported using an electronic online system. A fully online system had been introduced in April 2015. Staff across the organisation had a good understanding of how to report and escalate incidents.
- We had some concerns about the response to incidents particularly within critical care. Records from the National Reporting and Learning System (NRLS) between December 2015 and March 2016 highlighted five incidents. They were determined by the trust to pose no harm to patients. We looked at the descriptions of the incidents; the root cause was found to be staff shortage and the impact on patient care and safety. Although no harm occurred, there was no proactive action taken to minimise risk of recurrence.
- The trust had a serious incident policy and adverse event investigation procedure that outlined responsibilities and process for reporting and investigating incidents.
- We reviewed five serious incident reports and found these contained a full investigation and action plan.

- The trust held a quarterly assurance panel to seek assurance that action plans were complete and had been implemented for serious incidents and incidents requiring a root cause analysis.
- There was an identified liaison officer for the Central Alert Systems (CAS).
- The medication safety officer oversaw and managed patient safety alerts and medicines incidents. Medicine errors were reviewed by the Medication Safety Group, and the minutes of these meetings showed incidents were investigated but actions to prevent re-occurrence were not always clear. Ward staff told us pharmacists took part in their monthly clinical governance meetings and feedback was provided at ward level.
- The 2015 staff survey found the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month was better (in the top 20%) than the national average. The percentage of staff reporting errors, near misses or incidents witnessed in the last month was similar to the national average.
- The trust had been part of the 'sign up to safety' campaign since 2014.

Staffing

- The National Quality Board (NQB) published staffing guidance 'How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability' in November 2013. Within this document the NQB detailed ten expectations trust boards were expected to follow. We reviewed nurse staffing against these expectations:
- EXPECTATION 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.
- Reports were submitted to the Trust Board on a regular basis, which gave information on staffing levels and vacancy rates. There were twice yearly reviews of nursing and midwifery staffing in accordance with NICE guidance (2014). The Nursing & Midwifery Staffing Review October 2015 paper detailed information on a staffing review including staffing establishments, skill mix, tools used for identifying staffing needs and updated the Board on the national context. Nursing staffing levels were on the local and corporate risk registers and there was an action plan to reduce risk.
- At 30 November 2015, there were 2317.3 whole time equivalent (WTE) staff in post compared to a planned staffing of 2440.8

WTE. There were 990.9 nurses and healthcare support workers.The trust had a vacancy rate of 5%. There were challenges in maintaining staffing levels and recruitment was difficult for the trust in many areas.

- EXPECTATION 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.
- There were twice weekly rota planning meetings, with discussion about staffing three times a day at bed meetings.However, we identified concerns with nurse staffing levels in a number of areas across the trust. We raised these concerns with the trust at the time of the inspection. Staff told us it had been a difficult period, particularly over the winter. However, we found significant concerns within critical care. We looked at the bed occupancy status and the actual nursing staff levels for over 24 hour periods from 7 March to 14 March 2016. Of sixteen shifts, only one shift, a day shift on 10 March 2016 had the sufficient number of staff in line with national guidance (GPICS). The trust provided us with staffing data from 16 November to 31 December 2015. This period covered 46 days (92 shifts). The data highlighted during this period, for 17 (18%) shifts sufficient number of nursing staff on duty in accordance with national guidance. During the same period the health care assistants deployed to work on the unit showed 39% compliance.
- Within medicine , we reviewed 13 weeks of nurse staffing rotas for two wards; the number of registered nurses on a day shift was under the planned number for 68% of the shifts on ward 2 and 76% of the shifts on ward 10. Information submitted by the trust on nurse staffing rotas and number of beds open between December 2014 and March 2015, showed the ratio of nurses to patients on a day shift was greater than 1:13 on 47 occasions and the ratio of nurses to patients on a night shift was greater than 1:30 on 7 occasions. All the staff we spoke to told us the number of nurses was a concern.
- At the time of the inspection, surgical wards and department had 185.3 WTE registered and unqualified nursing posts (including critical care). We reviewed vacancy rates and this showed 20.8 WTE. We reviewed duty rosters for the previous three months and found that 136 shifts were staffed at below the established levels out of 315 shifts registered nurse shifts reviewed. Registered nurse staffing levels had been below established levels on all surgical wards over the previous three months.
- Within the ED, we reviewed four weeks of nursing off duty between November 2015 and December 2015. The percentage of filled qualified nurse shifts was between 80% and 96%.

Summary of findings

- There had been four occasions over the previous year when registered children's nurses from the children's unit had been asked to assist on the general wards. The trust management stated these staff were not expected to function as a registered nurse on the general wards.
- The average bank staff usage for April 2015 to January 2016 had been 6.0%.
- EXPECTATION 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.
- The Nursing & Midwifery Staffing Review October 2015 paper informed the Board of the use of the RCN evidence based tools used over the previous five years. These were used alongside professional judgement in conjunction with a system for identifying risk and escalating concerns. In addition, the review paper stated that the trust referred to the Safer Staffing Alliance (2013), which published guidance on minimum safe staffing levels on general wards. Appropriate evidence based tools had been used, for example in general ward areas, the safer nursing care tool had been used and the BEST tool had been used in the urgent and emergency care department.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. Staff told us that there were three registered children's nurses therefore; staffing was not in line with national guidelines. To mitigate the risk of only having three registered children's nurses, all nursing staff had received additional training during their induction regarding the care of children.
- The children's unit was not meeting the 2013 Royal College of Nursing (RCN) guidance on staffing. The shift supervisor was not supernumerary and there was not always the required nurse to patient ratio for the age of the child. The RCN recommend a ratio of one nurse to three patients for under two's and one nurse to four patients for over two's.
- The neonatal unit did not always have sufficient staff to deliver nurse to patient ratios for intensive care patients as set out in the DH toolkit for Neonatal Services (2009) and the British Association of Perinatal Medicine (BAPM) guidelines.
- Staffing of the maternity service was reviewed using the Birthrate Plus® midwifery workforce planning tool in accordance with the recommendations and procedures outlined in the NICE safe staffing guidelines. The service met the national recommendations for midwifery staffing every month between March 2015 and November 2015 with the

exception of July 2015 when the figure increased to 1:29 and in October 2015 where the figured peaked to 1:31. At the time of our inspection, the ratio was 1:28. The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). In comparison to the England average, the trust consistently had a lower ratio of midwifery staff to births.

- The unit remained challenged in delivering one to one care for all women during established labour. However, at the time of our inspection showed the number of women receiving 1:1 care had increased to 92%.
- Staffing levels within community services were generally good and staff said their workload was manageable. Community staff received clinical support from advanced nurse practitioners.
- EXPECTATION 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.
- The three bed meetings a day were used as a mechanism to identify and respond to concerns over staffing levels. In addition, the trust had introduced safety huddles so that other risks to patient safety and care could be discussed and actions taken. Staff also reported concerns over staffing levels and risks to patients through the electronic incident reporting system. Some staff told us that they would raise concerns about staffing levels. Following the inspection a number of staff contacted the CQC to raise concerns about staffing levels particularly on the critical care unit.
- The NHS staff survey (2015) found that the percentage of staff reporting satisfaction with the quality of work and patient care they are able to deliver was in the worst 20% of trusts nationally.
- EXPECTATION 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.
- We found that there was consultation amongst different professionals taking place when discussing and identifying staffing levels.
- EXPECTATION 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
- The Nursing & Midwifery Staffing Review October 2015 paper stated that the trust had piloted the impact of ward sisters in medicine being supernumerary of the winter period. Challenges to the achievement of this were due to staffing shortfall or increased demand in activity. The benefits to

working supernumerary were recognised, although acknowledged that this had not been possible more than 20% of the time. The trust was looking at how to improve this situation.

- In accordance with national guidance, critical care units must have a supernumerary clinical coordinator during each shift and one whole time supernumerary clinical educator. Although staff were given the responsibility for the roles, they did not have dedicated time to fulfil their responsibilities due to staff shortages.
- Ward sisters in many areas reported they did not get any management time due to staffing pressures.
- EXPECTATION 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.
- Each month, staffing data on the number of actual staff on duty for nurses/midwives and care workers compared to actual staff on duty. From this an exception report on nursing and midwifery staffing was presented at each Board of Directors' meeting. In May 2016, the nursing and midwifery staffing exception report paper to the board reported for April 2016, a 89.9% fill rate for registered nurses on day duty and 87.8% fill rate for registered nurses on night duty (ward 16). We reviewed evidence provided by the trust on the staffing levels for April which showed on 15 out of 30 early shifts (50%) the planned staffing levels were met, on 13 out of 30 late shifts (43%) the planned staffing levels were met and for seven out of 30 nights (23%) the planned staffing levels were met. The board paper also recorded there had been an increase in the number of incidents reported in relation to staffing, but there had not been noted any other impact of staffing on patient care. This was not consistent with the incident reports reviewed from 28 March and 10 May 2016.
- EXPECTATION 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.
- We found nursing staffing levels displayed within wards and departments. Staffing data was collected monthly on the actual compared to planned was displayed on NHS Choices.
- EXPECTATION 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.
- There was active recruitment to posts across the trust including from overseas. Approximately 29 qualified nurses had been

recruited from Romania and Croatia. There had been delays in the registration numbers for the international nurses leading to them not all being able to work in a trained nursing post earlier in the winter period.

- EXPECTATION 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.
- There was regular engagement between the commissioners of services and the trust, staffing issues formed part of this engagement.
- We had concerns about other staff groups across the trust, particularly pharmacists.
- Pharmacy staff we spoke with told us there was a staff shortage in the pharmacy. The pharmacy had a sickness absence rate of more than four per cent and had a number of unfilled vacancies within their structure.
- Ward staff told us there was limited pharmacy support and cover in place on wards due to staffing capacity within the pharmacy team. Pharmacy staff shortages had been identified on the pharmacy and trust risk register. Staff we spoke with told us this was adversely affecting medicines reconciliation, audits and ward support. Inadequate pharmacy provision can increase the risk of harm from medicines.
- Pharmacy staff we spoke with told us there was a staff shortage in the department. The department had a sickness absence rate of more than four per cent and had a number of unfilled vacancies within their structure.
- The trust had 43% medical consultants. This was better than the England average of 39%. There were 19% junior doctors, compared to an England average of 15%.
- Consultants at Airedale hospital critical care unit covered a 24 hour shift, which was between 8am and 6pm they were at the hospital and between 6pm and 8am the following day they provided on call cover. There were five WTE intensivists employed; the trust had tried to recruit anaesthetists with a special interest in critical care and recognised this was an area for improvement.
- The average locum medical staff usage across the trust for April 2015 to January 2016 had been 12.8%.
- The locum usage in the critical care unit, between April 2015 and January 2016, averaged 12.7% and in August 2015 the usage increased to 23.5%.
- According to the College of Emergency Medicine (CEM) (2015), an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend. The trust had

recognised this and there was a commitment to invest in additional consultants for ED to increase the team to 10 wte. At the time of inspection, there were seven whole time equivalent (WTE) ED consultants employed by the trust, with an additional full-time consultant recruited. Within children's services, acute paediatrics had consultant cover on site 24 hours a day, seven days a week. This was good practice. However, the medical staffing rota was not fully compliant with Royal College of Paediatrics and Child Health (RCPCH) or British Association of Perinatal Medicine (BAPM) guidelines. RCPCH standards recommend that all general paediatric training rotas are made up of at least ten whole time equivalent posts. The trust was not meeting this standard and it had been identified on the risk register that there were an inadequate number of junior doctors on the paediatric rota. The trust was using locums to cover. The risk register also highlighted a risk from not having enough acute paediatric consultants. A business case had been approved to increase the number of acute paediatricians to 10.

Medicines management

- The pharmacy department was open from 9am to 4pm on Saturday and 10am to 12.30pm on Sundays for discharge medicines supply. An on call system was available outside these times. We saw details of delayed discharges at the weekends due to discharge medicines not being available.
- Trust medicines management policies and Standard Operating Procedures (SOPs) had recently been reviewed and updated and covered key aspects of medicines management. These were accessible via the hospital intranet to all staff, but we saw these were not always followed at ward level. For example, the SOP for "Temperature monitoring of fridges used for the storage of medicines and vaccines and wards and departments" stated action should be taken if temperature readings are outside the range two to eight Celsius. On four wards we visited, fridge temperatures had regularly been outside this range but there were no records of actions taken. We saw examples where wards had printed off trust policies and these were not the most up to date version.
- Medicines were stored securely throughout the trust, however medicines were not always stored appropriately. For example, we saw expired medicines in three fridges, and on two wards medicines for discharged and deceased patients was stored with medicines for current patients. We saw details of incidents

where patients had received incorrect medicines or missed doses of their medicines because medicines had been stored in the wrong place or not been transferred with them when they moved wards.

- The hospital discharge checklist staff showed us did not include any reference to checking if a patient brought their own medicines to hospital with them or if fridge items needed to be supplied on discharge. We saw the trust medicines safety group meeting log included incidents about patients who had been discharged with the wrong insulin, suggesting the discharge process for fridge items is not robust. We saw details of medicines incidents where patients had been discharged with medicines meant to be given to someone else. This suggests the medicines discharge process was not always followed correctly.
- Medicines records were completed using an Electronic Prescribing and Medicines Administration (EPMA) system. This had a number of benefits in terms of the safety and quality of services provided for patients: it was easy to distinguish if a pharmacist had screened medicines for clinical appropriateness or supply. However, the system was not in use throughout the trust as a phased implementation was in progress. The use of paper charts alongside or instead of EPMA meant there was an increased risk of medicines being missed, duplicated, or incorrectly transcribed when patients were transferred to other wards. This had been identified on the Digital Care Programme risk register as this strategic group was overseeing the implementation and roll out of this work. There were plans to roll out electronic prescribing to the rest of the trust in the near future.
- Staff had identified some issues with prescribing using this EPMA system, but the trust were taking action to investigate these. For example, one staff member told us there were concerns that two clinicians could be in the same persons record at the same time making changes and there was no alert on the EPMA system to identify this. Trust managers informed us there was an automatic alert on EPMA to highlight if a user attempted to open a patient's record whilst already being accessed by another user.
- Pharmacy staff checked (reconciled) patients' medicines on admission to wards. There was a dedicated pharmacy team on the admissions ward however this was not a seven day service. The ward-based clinical pharmacy service was not available on all wards and was a predominantly Monday to Friday service. The trust's most recent audit, titled pharmacy medicines reconciliation within 24 hours of admission, last conducted in

December 2015, showed medicines reconciliation had been completed within 24 hours for 47% of patients. The audit did not specify the difference in medicines reconciliation rates between week days and weekends and included 14 of the 16 inpatient wards in the trust. National guidance [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE 2015] states this should be completed within 24 hours for all patients.

- Some aspects of medicines management were audited across the trust. Audits included medicines reconciliation, omitted doses, safe and secure management of controlled drugs storage, and clinical pharmacist interventions. However, there was a lack of clear action plans following audits and there was not a comprehensive overarching audit schedule that covered all audits. Staff told us staffing pressures in the pharmacy department had resulted in other activities such as certain audits being delayed.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust governance arrangements. There was an open culture around the reporting of medicine errors. The medicines safety officer had oversight of incidents across the trust however, we saw repeated occurrences on our inspection suggesting learning was not embedded at ward level. For example, there were repeated incidents with the application of pain killing patches. Some cases resulted in duplicate patches being applied, because the old patch had not been removed. This leaves patients at a higher risk of side effects.
- Patients were not routinely supported or encouraged to manage their own medicines. None of the patients we reviewed were self-administering medicines. The trust had identified this issue, and a self-administration policy had been developed and we were told a pilot was being trialled on one ward.
- Patient Group Directions (PGDs) were in use in some clinical areas of the trust. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. The trust had a robust system to ensure these were kept up to date.
- There were a small number of non-medical prescribers (NMP) in the pharmacy team. During our inspection, we saw limited examples of how this helped ensure patients received medicines in a timely way. Additional NMP training had been planned, but was constrained by staffing pressures. One pharmacist was not able to use their additional qualification to its full potential.

Summary of findings

Assessing and responding to risk

- The critical care unit used telemetry equipment to monitor the heart rhythm of patients on wards remotely and send information to a screen in the unit. However, critical care staff were not always available to monitor the data and respond in a timely manner so that the information was effectively used.
- The trust used a national early warning score (NEWS) which indicated when a patient's condition may be deteriorating. An acute care team was available 24 hours a day, seven days a week to support staff with patients who were at risk of deteriorating, patients whose NEWS score triggered a review, patients on NIVand patients who had invasive lines, for example central venous catheters and peripherally inserted central catheters.
- We reviewed 46 observation charts in medical wards and found that the NEWS scores were completely appropriately and, where necessary, there had been escalation in accordance with the guidance on 31 charts. However, this was meant that staff did not carry out observations or escalate NEWS scores in line with the guidance for one third of the charts reviewed. There was a risk staff would not recognise the deterioration of a patient in a timely manner.
- There were also concerns about the deteriorating patient within surgery. We reviewed ten NEWS scores and found four required escalation. From the actions we reviewed, three did not have appropriate escalation. In one of the cases we reviewed, staff had not taken the appropriate action, despite the patient scoring a high NEWS score; during the inspection, we highlighted this patient to the Matron.
- Observations for patients on non-invasive ventilation on the respiratory ward were not completed in line with the recommendations from the trust's NIV flowchart for acidotic exacerbations of COPD.
- The hospital used the five steps for safer surgery procedures including the World health Organisation (WHO) safety checklist. The hospital demonstrated compliance with the safety checklist via internal audit. Results we reviewed for January 2016 showed 88% compliance with sign in, 95% compliance time out and 78% compliance with sign out. During the inspection, we watched sign in and time out performed. We reviewed three sets of post-operative surgical notes containing WHO checklists and we observed one completed accurately, onesign out not completed and no records were available for the third. Staff we spoke within theatres stated that the checklist required further embedding.We reviewed key performance indicator audits carried out on retrospective notes

Summary of findings

reviews which showed during the reporting period September 2015 to November 2015, 96% (average) compliance with sign in, 98% (average) compliance with time out and 94% (average) compliance with sign out.

Are services at this trust effective?

Good

We rated effective as good because:

- Mortality indicators showed the trust was within the expected range or lower than expected. ICNARC data showed the mortality outcomes for patients in the critical care unit were similar to comparable services.
- Outcomes for patients were mostly the same as or better than the England average.
- A consultant-led mortality group reviewed potentially avoidable deaths and a random selection of unavoidable deaths as part of the assurance and learning process.
- There was effective use of telemedicine. The digital care hub housed the intermediate care hub, the gold line service which provided care for patients in the last 12 months of their life, and the telemedicine service.
- Most staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.

However, we also found:

- Some of the trust's policies and guidance was overdue for review. It was unclear if staff were always using up to date guidance.
- At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 38% of nursing staff.
- Pain relief was not always offered or provided in a timely way within surgical areas.
- DNACPR decisions were not always made in line with national guidance and legislation.

Evidence based care and treatment

- Policies and guidelines were available to staff on the trust's intranet.
- Policies and guidelines were mostly based on relevant evidence base and best practice from appropriate professional bodies.
- The trust had a National Guidance Implementation Policy to ensure there was a systematic approach to national clinical guidance

- However, some of the guidance was overdue for review. For example, ,the cellulitis pathway was overdue for review from January 2016 and in maternity and gynaecology services, we found 22 were out of date.

Patient outcomes

- The trust was within the expected range or lower than expected for key mortality ratios.The Summary Hospital - level Mortality Indicator (SHMI) for October 2014 to September 2015 was 0.93, and below the national average (1.0) and within expected range. The Hospital Standardised Mortality Ratio (HSMR) for January to December 2014 was 85.4, which was lower than expected. The weekday HSMR was 83.4, lower than expected and the weekend ratio was 92.3, which was in the expected range.
- There were no active mortality outliers identified by the Care Quality Commission at the time of inspection.
- A consultant-led mortality group reviewed potentially avoidable deaths and a random selection of unavoidable deaths as part of the assurance and learning process.Standardised case note review had been introduced in collaboration with the Academic Health Science Network and incorporated the quality of care at the end of life.
- ICNARC data showed the mortality outcomes for patients in the critical care unit were similar to comparable services.
- The trust participated in the Royal College of Physicians national audit of inpatient falls. Falls per 100 bed days was highlighted but the trust was not an outlier. An action plan had been developed following this audit through the falls steering group and addressed the areas of non-compliance such as assessment of vision, documentation of the diagnosis of delirium and checking of lying and standing blood pressure. Work was ongoing to ensure compliance with NICE guideline CG 61 falls in older people: assessing risk and prevention.
- The Sentinel Stroke National Audit programme (SSNAP) level had improved from an overall E in July to September 2014 to an overall C in April to June 2015. Two components remained at level E; these were speech and language therapy and multidisciplinary working.
- The national diabetes inpatient audit (NaDIA) 2015 indicated that out of 19 indicators the trust was better than the England average in 17 areas and worse in two. Of specific concern were indicators relating to foot risk assessments The trust accepted this remained a concern from the 2013 audit and an action plan was being developed to address this. The Myocardial Ischaemia National Audit Programme (MINAP) audit 2013/14 indicated

that the trust was worse than the England average for non st elevated myocardial infarction (NSTEMI) patients admitted to a cardiac unit or ward and NSTEMI patients that were referred for or had angiography. It performed better than the England average for NSTEMI patients seen by a cardiologist or member of the team.

- The national heart failure audit 2012/13 showed that the trust had performed worse than the England average in three of the four in-hospital care indicators. It also scored lower for three of the seven discharge indicators and in line with, or better than, the England average for the other four. Specific areas of concern were input from a specialist, input from consultant cardiologist, referral to cardiology follow up and referral to a heart failure liaison service.
- The trust had achieved Joint Advisory Group on GI Endoscopy (JAG) accreditation. JAG Accreditation is formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against recognised standards.
- The national bowel cancer audit (2015) showed the trust performed worse than the England average in two of the three comparable indicators, including discussion at MDT and seen by clinical nurse specialists. Laparoscopic surgery was attempted on 72.9% vs. the England average of 54.8%. The trust had a good case ascertainment rate at 100%, and a good level of data completeness at 94%.
- We found that the emergency laparotomy organisational audit 2014 showed that of the 31 items audited in the National Emergency Laparotomy Audit 2014 the hospital had only 10 available, with two available on request. For the 2015 patient audit, the trust scored green in three out of 11 outcome measures; seven scored amber and one scored red, less than 50% of patients had an assessment by MCOP specialist where the patient was aged over 70 years
- The lung cancer audit (2015) scored higher than the England average in two indicators; 100% of patients were discussed at a multidisciplinary team meeting which was better than the England average of 93.6%, and 100% of patients also received CT before bronchoscopy. The third indicator of the lung cancer audit indicators showed similar results to the England average; the trust had 13.7% of patients received surgery compared to the England average of 15.4%.
- The trust participated in the national hip fracture audit 2015. Findings from the report showed that the trust performed better than the England average for six out of the eight indicators. Performance was worse for patients admitted to an orthopaedic ward within four hours with 40.8% compared to

the England average of 46.1%, and for mean length of average stay (17.5 compared to the England average of 15.7); however, surgery on the day of or after day of admission was higher 75% than the England average 72.1%.

- Patient reported outcome measures (PROMs) for groin hernia, hip replacement and knee replacement showed that the trust performed similar to the England average for all measures.
- The trust took part in the 2013/14 Paediatrics Diabetes Audit. The results from the audit showed that 19% of patients had a HbA1c of less than 58mmol/mol (indicating controlled diabetes) compared to an England average of 18.5%. The trust reported a mean HbA1c of 71.2. This was in line with the England average of 71.7.
- Between July 2014 and June 2015 the multiple readmission rate for asthma patients aged 1-17 years old was 18.1%. This was worse than the England average of 16.8%.
- Between July 2014 and June 2015 the multiple readmission rate for epilepsy patients aged 1-17 years old was 27.3%. This was in line with the England average of 27.8%.
- Three out of five questions in the national neonatal audit programme (NNAP) 2014 met or were above the NNAP standard.
- Within community services, the cardiac rehabilitation service used the Hospital Anxiety Depression Score (HADS) to measure improvement in patient outcomes. They also used the 'shuttle work test' to test patients at the beginning and end of their treatment program to measure an improvement in their condition. An audit showed that there were significant benefits for patients who completed the cardiac rehabilitation exercise classes with an increase in functional exercise capacity, and a decrease in anxiety and depression.
- The results of the National Care of the Dying Audit for Hospitals (NCDAH) had showed improvement over the last two years. The national results published in March 2016, showed Airedale hospital was better than the England average in four out of five clinical quality indicators (QI), and the same as the national average in the other clinical QI. Examples of the achievements were; there was evidence the patient had their concerns listened to, and evidence for individual plans of care. Ten out of ten organisational QIs were achieved.
- The trust held Clinical Pathology Accreditation (CPA) for the pathology services.
- We saw effective use of telemedicine. The digital care hub housed the intermediate care hub, the gold line service which provided care for patients in the last 12 months of their life, and the telemedicine service.

Summary of findings

Multidisciplinary working

- There was good evidence of effective multidisciplinary working across the trust.
- Within the community, there were two collaborative care teams. All teams were multi-disciplinary and included occupational therapists, physiotherapists, registered nurses, mental health nurses and health care support workers. Advance Nurse Practitioners (ANPs) were also based with the teams. Social care assessors funded by another organisation were based within one of the teams and staff told us this worked very well as they held daily discussions on their patient's progress and future plans. Multi-disciplinary Team (MDT) meetings were held twice daily.
- The community heart failure specialist nurses worked closely with staff on the acute medical wards.
- Community nurse specialists contributed to discussions at multidisciplinary team meetings at GP surgeries and on the hospital wards when required.
- Social care and healthcare staff worked together in the integrated intermediate care hub.
- A frail elderly pathway team that consisted of therapists and therapy assistants was introduced in 2014. They assessed and planned care for patients who were medically fit in the emergency department, ambulatory care unit and acute medical unit.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Most staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards. Over 86% of staff across the trust had received training on the Mental Capacity Act.
- There were policies and processes in place to ensure patients gave consent in line with department of health guidance.
- The trust had developed bespoke surgical MCA training, annual audits on consent form usage to be undertaken and had reviewed locum medical staff consent competencies following an investigation into a serious incident regarding consent.
- The surgical group completed an audit of consent. The audit in October 2015 showed that on the standards measure 11 out of the 15 standards assessed scored 100% scores. Low scores (21%) were noted on whether other possible treatments had been discussed standard. However, this was a 3% improvement on 2014 data.

Summary of findings

- During the inspection, we saw there were ten patients on one ward with a DoLS in place. We reviewed these and found they were all appropriate and the process had been followed accurately.
- We reviewed 30 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.
- We were concerned that DNACPR decisions were not always made in line with national guidance and legislation, for example the Human Rights Act, Equality Act and Resuscitation Council (UK) guidelines. We saw in three instances (10%) patients did not have capacity to be involved in resuscitation decisions and there was no evidence their family had been consulted. Two forms (6%) indicated the reason for DNACPR was the patients were 'housebound' and of a 'great age'. These were not valid clinical reasons for such a decision.

Are services at this trust caring?

Good

We rated caring as good because:

- Throughout the inspection, we observed staff providing compassionate care across the organisation.
- The trust scored the same as or better than other hospitals across a range of patient surveys for issues such as privacy, dignity and involvement in decisions..
- There was a range of clinical nurse specialists at the trust who supported patients with complex or long term conditions, for example, in diabetes, stroke, palliative care and haematology and oncology.
- The trust had a midwife with a specialist interest in bereavement. Families emotional needs were valued by staff and the service had involved families who had experienced the loss of a baby to redesign facilities for other bereaved families.

Compassionate care

- The percentage of patients that recommended the trust in the Friends and Family Test (FFT) had steadily improved since January 2015 and had exceeded the England average since March 2015. In November 2015, the trust performance was 96.7% compared to a national average of 95.7.
- Throughout the inspection we observed staff providing compassionate care across the organisation. We saw examples were staff demonstrated a sensitive and supportive manner to patients and families who came to the hospital, such as the bereavement officer.

- In the CQC Inpatient Survey (2015) the trust scored the same as other trusts for being treated with respect and dignity and for feeling that they were well looked after by hospital staff.
- The trust was in the top 20% for nine of the 34 questions in the Cancer Patient Experience Survey (2013/14). It was in the bottom 20% of trusts for one question.
- The trust performed better than the England average for all four areas, including privacy, dignity and well-being in the 2015 Patient Led Assessments of the Care Environment (PLACE).
- In the CQC's 2014 A&E survey, the trust scored the same as other trusts in 22 of the 24 questions relating to caring with an overall score of 7.8 out of 10. They scored better than other trusts on the other two questions.
- The maternity service undertook monthly inpatient surveys. Real time survey results for October 2015 showed 100% of patients had confidence in the staff, 97% felt cared for during labour, 100% were treated with kindness and understanding and 88% felt supported with feeding and had the chance to discuss any concerns.
- In the CQC Maternity Services Survey (2015) the trust scored better than other trust for patient's experiences during labour and for being able to move around and choose the most comfortable position during labour. The trust scored about the same as other trust for care received by staff during labour, birth and postnatal care.

Understanding and involvement of patients and those close to them

- In the CQC Inpatient Survey (2015) the trust scored the same as other trusts for being involved as much as they wanted to be in decisions about their care and treatment and for being involved in decisions about their discharge from hospital, if they wanted to be.
- In the CQC Accident and Emergency Survey (2014) the trust scored the same as other trusts for being involved as much as they wanted to be in decisions about their care and treatment
- In the CQC Maternity Services Survey (2015) the trust scored the same as other trusts for both women being involved enough in decisions about their care during labour and birth about the same and partners being involved as much as they wanted.
- Within maternity services, results from the monthly inpatient survey for October 2015 showed that 97% of patient's felt involved in decisions and understood the information given and 72% had birth plans.

Emotional support

Summary of findings

- In the CQC Inpatient Survey (2015) the trust scored the same as other trusts for receiving enough emotional support, from hospital staff, if needed.
- There was a full time Church of England chaplain, and part time chaplains from other faiths. There were 35 chaplaincy volunteers including Buddhists and Muslim volunteers.
- The trust had a midwife with a specialist interest in bereavement. Families emotional needs were valued by staff and the service had involved families who had experienced the loss of a baby to redesign facilities for other bereaved families.
- There was a range of clinical nurse specialists at the trust who supported patients with complex or long term conditions, for example, in diabetes, stroke, palliative care and haematology and oncology.
- We observed 'pets as therapy' visits on the wards. Research has shown that therapeutic visits from dogs can provide comfort and companionship to patients in hospital and relieve anxiety and stress.
- Within the community services, staff used motivational interviewing to encourage patients to self-care where this was appropriate.
- Mental health nurses worked in the collaborative care teams and could offer assessment and treatment to patients with mental health conditions.

Are services at this trust responsive?

Good

We rated responsive as good because:

- Systems were in place to identify and meet the needs of individuals, including patients with a learning disability or living with dementia.
- The Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival was met in eight of the 12 months prior to the inspection in March 2016. The trust had consistently been better than the England average except for June 2015 when it was 94.2% compared to 94.8%.
- The target referral to treatment time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment time. Between September 2014 and August 2015 the trust consistently met the 92% standard for patients on an incomplete pathway.
- The telehealth service provided immediate access to expert opinion and diagnosis and was available 24 hours a day, seven days a week.

However, we also found that:

- Patients well enough to leave the critical care unit experienced delays being transferred to a ward more conducive to their recovery.
- Patients who required rehabilitation and/or emotional support following treatment in critical care were expected to source their own services.
- During 2014/15, 36% of complaints were responded to within 40 days. The trust had introduced a new system from October 2015 to manage complaints to improve the timeliness of response and ensure an appropriate investigation involving the right members of staff.

Service planning and delivery to meet the needs of local people

- The trust provided acute and community services. Community services joined the trust in 2011 as part of the transforming community services programme and served the population of Airedale, Wharfedale and Craven.
- The service crossed three local authorities; the trust had systems in place to ensure good communication.
- Services were commissioned from three Clinical Commissioning Groups; there was a lead CCG identified for the trust.
- The trust had redesigned the stroke pathway in conjunction with a local NHS organisation. Staff proactively planned repatriation from the hyper acute stroke unit and had achieved the target from July 2015 to the time of the inspection.
- We saw services for community adults were planned by close working and engagement with other organisations and local Clinical Commissioning Groups.
- The trust was part of the Airedale Partner's Enhanced Health in Care Homes Vanguard. This involved close working, planning and developing relationships with other organisations and neighbouring trusts.

Meeting people's individual needs

- The hospital had identified matrons in medicine, surgery, day surgery and outpatients play as lead nurses for patients with learning disabilities and their carers. There was no dedicated specialist nurse role.
- The matrons liaised with the community LD teams in Craven and Bradford and Airedale and attended the local community task group in Craven and the regional Yorkshire and Humber Access to Acute meetings. The community LD nurses made contact with the lead matrons when their patients were admitted.

- An electronic flagging system alerted the matrons and the deputy director of nursing via an email identifying when and where a patient with learning disabilities was admitted or attending an outpatients appointment.
- There was a flow chart which provided nursing guidance for the management of a patient with a learning disability. This was accessible to staff on the trust's intranet.
- The trust did not audit the care given to people with learning disabilities. They had adapted an Essence of Care benchmark for patients with learning disabilities to be used at the end of the episode of care to allow staff to reflect upon care and action plan for further improvement.

Dementia

- The trust had an electronic notification system for patients admitted to the service with a known diagnosis of dementia. The alert was received by the practice development sister for older people, safeguarding team and the Assistant Director for Patient Safety.
- There was no specialist nurse for dementia, however, a practice development sister for older people was in post and took a lead role. The trust had a dementia action plan.
- The trust had implemented the Butterfly scheme. The Butterfly scheme provides a system of hospital care for people living with dementia. A butterfly icon was displayed on the bed management screen so that staff were made staff are aware the patient required a Butterfly Care Plan. We found the butterfly care plan in use on the wards we visited.
- Within the emergency department, there was a specific 'dementia friendly' cubicle. However, during our inspection we saw patients nursed in this room who did not have dementia (when other cubicles were available), and patients with dementia nursed in another cubicle.
- Some medical wards had been refurbished and were dementia friendly environments; bays were marked with different bright, bold colours. Ward 4 had a reflections room, a dementia garden and volunteers supported a memory café once a week.
- Patients over 75 were screened for dementia using the dementia screening tool.
- Within the adult community health service, there was a dementia crisis prevention team in place who helped patients with dementia or memory problems avoid getting into an unnecessary crisis. The team was a partnership between Airedale NHS Foundation Trust and other organisations. The

team included community mental health nurses, community nurses, occupational therapists, dementia support workers and community support workers covering Airedale, Wharfedale and Craven. There was also a dementia response team.
- The trust undertook a monthly carers audit to understand the hospital experience of patients with dementia and cognitive impairment.
- Evaluation of the dementia crisis prevention and response teams in 2015 had found positive feedback from referrers, patients and carers reflecting an improved experience.
- The trust had signed up for a national campaign to further improve dementia care.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. In eight of the last 12 months prior to the inspection in March 2016, the trust exceeded the standard of 95%. The trust had consistently been better than the England average except for June 2015 when it was 94.2% compared to 94.8%.
- Between July 2014 and October 2015, the general median time to treatment was consistently worse than both the standard of 60 minutes and the England average.Over the winter period (November 2014 to March 2015) there were 88 ambulance hand-overs delayed for over 30 minutes at this trust, putting the trust in the bottom 20% of all trusts in England for numbers of delayed handovers which is an indication of good performance.
- Between October 2014 and November 2015 there were three black breaches at this trust where handovers from ambulance arrival to the patient being handed over to the Emergency Department took longer than 60 minutes.
- Between 1 September 2014 and 31 August 2015 there were 118 people waiting four to 12 hours and one person waiting over 12 hours from decision to admit to admission. Between December 2014 and November 2015 the percentage of patients waiting four to 12 hours was consistently worse than the England average.
- The target referral to treatment time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment time. Between September 2014 and August 2015 the trust consistently met the 92% standard for patients on an incomplete pathway. However, all surgical specialities other than ophthalmology and ear, nose and throat were performing lower than the RTT standard.

- We reviewed the cancer targets and noted that performance was better or similar to the England average in all performance measures.
- We saw information from NHS England 'Delayed Transfers of Care Data 2015-16' and trust documents which indicated delayed transfers of care from hospital to other care settings were increasing. Trust documents indicated this impacted on the flow of patients through the hospital.
- One reason for delayed discharges was 'patient or family choice' in waiting for a nursing home bed. We saw this had been reviewed on the trust risk register in December 2015 and February 2016.
- A safer flow bundle had improved the relationships with local authorities and social care.Case managers identified patients with a length of stay of more than14 days and those who had a complex discharge. They worked with patients and the single point of care hub and reduced this number of patients from 80 to between 40 and 50.
- The trust held bed meetings three times a day increasing to four times daily, if required. An escalation policy was in place.
- The intermediate care hub was based at the digital care hub at Airedale General Hospital. The service provided a single point of access for GPs, nursing staff and other health professionals referring patients with intermediate care needs.
- The telehealth service provided immediate access to expert opinion and diagnosis and was available 24 hours a day, seven days a week. We were told that staffing at the hub was increased in the evenings, on weekends and bank holidays, as this was when demand was highest.
- Patients in nursing and care homes were triaged using telemedicine prior to putting the call through to GPs to request a visit. The service could demonstrate that it had averted approximately 30% of calls from needing to go through to a GP.

Learning from complaints and concerns

- The trust had a complaints management policy, which was due for review in March 2016.
- A total of 103 formal complaints were received and investigated by the trust during 2014/15.
- The trust's local standard aims for responses to be sent within 25 and 40 working days of receipt of the complaint; timescales were discussed with the complainant and agreed. Responses were signed by the Chief Executive.
- The trusts annual complaints report for 2014/15 identified that 37 (36%) of complaints were responded to within 40 days.

Summary of findings

Eleven (10%) took 81 and 150 days for a response to be issued. The key reason provided for the extended length of time was the unforeseen complexity of a complaint which became apparent during an investigation.

- The trust had introduced a new system from October 2015 to manage complaints to improve the timeliness of response and ensure an appropriate investigation involving the right members of staff.
- On receipt, the complaint was risk assessed to determine the level of investigation and determine the main stakeholder. During the inspection, we reviewed five complaints files. We saw the complaints were risk assessed. However, it was not clear within the files how the decision from the risk assessment determined the action to be taken.
- Complaints were reviewed by the individual service delivery group governance meetings and individual specialty governance meetings and as a standard item on Clinical Speciality Assurance Committees (CSAC), Group Governance Meetings, Clinical Specialty Governance Meetings, Nursing and Midwifery Leadership Group and the matron's forum.
- The number of complaints was reviewed by the Board. All complaints reviewed by the Parliamentary Health Service Ombudsman were presented to Board. Complaints were reviewed by some members of the Board and all were signed by the Chief Executive. However, there was no evidence that all the Board saw the detail of all complaints. An annual report on complaints was presented to the Board.
- We saw examples of changes to practice that had been made following complaints. However, this was not always clearly documented in the complaints files that we reviewed.

Are services at this trust well-led?

Requires improvement

- There was a governance framework in place. However, we found that the systems did not promote sharing of information consistently between trust level staff and the front line workers within the hospital.
- There was lack of evidence at trust board level that the governance framework and management systems were effective in all areas of the trust.
- The executive team had taken steps to address some of the concerns raised by staff regarding support from managers. However, some staff raised concerns about the style of leadership and management of the service in critical care, medicine and surgery, which were not being sufficiently addressed by the executive team.

Summary of findings

- We found there was a lack of effective response to some incidents and management of risks.

We also found:

- There was a trust-wide organisational vision titled 'Right Care'. This was known and understood by staff across the organisation.
- There was positive patient and public engagement.
- There were some innovative examples of practice, such as telemedicine in combination with the intermediate care hub, nursing and care home residents and their carers benefitted from being able to access expert advice and support remotely 24 hours a day, 7 days a week.

Vision and strategy

- The trust had an organisational vision titled 'Right Care'. This aimed to place the patient at the centre of their care, involve them in decisions, give them information to take part and allow them to orchestrate their care.
- We found that the vision was known and understood by staff across the organisation.
- The trust had a Quality Improvement Strategy for 2015 – 2018. The strategy stated there was annual planning and review with each clinical group against the objectives of the Quality Improvement Strategy.
- We found some directorates had strategic plans that supported the trust's vision and strategy. However, this was not evident in all areas; for example there was no clear short or long-term strategy for maternity and gynaecology services or critical care. There was no evidence at trust board level that there were any plans to address this issue. The nursing and midwifery strategy was being updated. A draft strategy for 2016 to 2020 was being consulted upon. This referenced key national quality initiatives.

Governance, risk management and quality measurement

- The trust had a unitary board, with four sub-committees providing assurance. These were the clinical speciality assurance committee, the audit committee, the charitable funds sub-committee and the board appointments and remuneration committee.
- There was a Board Assurance Framework (BAF) in place with objectives identified.

Summary of findings

- At our last inspection in 2013, we found the trust board showed a good understanding of key issues across the trust. This was supported by an external review of governance in 2014, which found good systems of control in place to give the board assurance across the breadth of trust activity.
- However, at this inspection we were not assured that the systems in place were effectively identifying and managing quality and risk. Although, there was a clear governance structure from ward to board, there was a lack of evidence that the governance framework and management systems were effective and that staff were familiar with the processes of reviews and improvements to the service. For example on the critical care unit, there was no formal programme of clinical and internal audits for monitoring the quality of the service. In the surgical services, although there was a clinical audit in place, changes made following audit were not always clear.
- Services held clinical governance meetings and risk registers were in place. However, there was a concern that risks were not always identified and reported at service level, and subsequently trust level, to ensure effective governance and risk management.
- A corporate risk register was in place. However, although there were actions identified to address or mitigate identified risks, these were not always given the priority expected and so were not dealt with in a timely manner. For example, the build-up of excessive numbers of paediatric notes waiting to be typed, including records dealing with discharge notes for use by other professionals and safeguarding matters, was identified on the risk register in May 2015. During our inspection in March 2016, we identified a significant backlog of these paediatric notes. We concluded that there was insufficient management and monitoring to manage the risk. We raised this at the time of inspection and the trust took immediate actions to address the situation. The trust has been providing weekly updates on the progress with dealing with this backlog, which has been reducing since the inspection.
- Some risks identified on the corporate risk register were not comprehensive. The risk relating to nurse staffing did not identify risks or non-compliance with national guidance for critical care or paediatrics.
- We were not assured that incidents were effectively managed by the trust board. Following our inspection in March 2016,the Trust informed us of a serious incident that had occurred on the critical care unit. A trust director was asked to provide assurance and audits regarding checks in place to minimise the risk of recurrence. This was not provided. We were not provided

with information that sufficient assurance had been undertaken following the serious incident. Subsequently, we spoke with the Chief Executive to ensure additional actions were taken. We have continued to monitor the trust to ensure action has been taken. Concern had also been raised regarding the management of patients on telemetry. Actions identified following an incident had not been fully completed.

- The process for ensuring guidance and policies were in place and up to date was not effectively managed; we found policies and guidance that was past the scheduled review date in many areas of the trust.
- Information to the board included a monthly integrated governance dashboard, which was RAG (red, amber or green) rated to identified levels of risks or poor performance. The dashboard covered a range of issues including performance measures, untoward incidents and staffing issues. For example, the October 2015 integrated dashboard reported the Family and Friends Test response rate was below the required threshold for both in-patients and ED and the leaver turnover rate showed an improved position.
- There was a high level nursing dashboard that included documentation of audit data on falls, pressure ulcers and safety thermometer information. However, there was no ward, department or team dashboard that would bring together a range of metrics to identify concerns, so they were identified at an early stage and could be responded to. We saw some local development of tools, but this was not consistent across the trust.
- During our inspection, we found that the systems in place did not promote sharing of information consistently between trust level staff and the front line workers within the hospital. In some areas such as the critical care unit not all information shared with band 7 nurses and above were being shared with staff on the ward areas and there was inconsistent minute taking at meetings.
- We considered the ten expectations according to the National Quality Board (NQB) staffing guidance that trusts should implement and identified some gaps. The director of nursing undertook a twice yearly review of nurse staffing, in accordance with NICE guidance. However, this did not identify some speciality areas, such as critical care, or consider staffing against national, speciality specific guidance. Exception reports were presented to the trust board for nursing levels on wards that fell below 90% fill rates. A proposal for an increased investment in nursing staff was due to go the May Board meeting for £1.8million.

Summary of findings

- As of February 2016, the staff vacancy rate had improved to 4.2%. Staff sickness rate reported in February 2016 was around 3.8% against a target of 3.6%. We were told that there had been a lot of work around the health and well-being of staff and to support staff back to work.

Leadership of the trust

- At our last inspection in 2013, we found that Airedale General Hospital was well led. The external governance review in 2014 also identified the trust had a strong board with a strong team in terms of composition and capabilities, which allowed it to exercise leadership that was highly, respected both internally and externally.
- At this inspection, we found there had been a number of changes to the trust board since the previous inspection in 2013. The chairperson and medical director had been in post since 2014 and the director of strategy and partnerships role was vacant and in the process of being recruited to. The Director of Operations has been part of the Executive Team since July 2013, but has been an voting member of the Board of Directors since 2015.The Chief Executive was the longest serving executive and had been in post for five years.
- There was a body of governors who teamed up with the non-executive directors in buddying arrangements. Governors reported that they felt informed of issues at the trust and were able to be involved in various aspects of the work undertaken by the leadership team such as the review of stroke services. The governors met monthly, with the council of governors meeting four times a year. There was around 10,000 members.
- The trust was led through a divisional structure, which included three clinical divisions. There was a triumvirate structure within divisions with accountability shared between clinical directors, the general manager and senior matron. This senior group leadership team reported through to the Director of Operations; the clinical directors and senior matron remained professionally accountable to their board professional leads. The executive team had led a consultation with senior staff in the service groups about further developments to leadership and management arrangements. At the time of inspection, the senior leadership team had commenced work to strengthen the clinical leadership, accountability and governance arrangements.
- The Board and senior leadership team were aware of issues in relation to leadership and management and, as part of their

'people plan' had invested in developments including the 'Right Care New Leaders Programme' for new clinical leaders, executive coaching and a 'rising stars' leadership development programme for staff at band 1-7.

- The NHS staff survey (2015) found the percentage of staff that got support from their immediate managers was slightly worse than the national average, but had improved from 2014. The NHS staff survey (2015) also showed recognition and value of staff by managers and the organisation was similar to other acute trusts.
- The executive team had taken steps to address some of the concerns raised by staff regarding support from managers. However, some staff raised concerns about the style of leadership and management of the service in critical care, medicine and surgery, which were not being sufficiently addressed by the executive team.
- Sickness absence rates were largely in line with the England average.
- The National Training Scheme Survey from the General Medical Council (2015) assessed the trust as performing as expected in all 14 indicators.
- We found 87% of staff had an appraisal including medical staff.

Culture within the trust

- At the previous inspection in 2013, the culture felt overall positive. Prior to this inspection, we received concerns from individuals and a professional body regarding the style of leadership and management in a service. Senior managers were aware of this and explained what actions they had taken to gain assurance about the organisational culture.
- During the inspection, we found there was a mixed picture regarding the culture across the organisation. Staff were proud to work for the trust and most felt supported. However, some clinical staff expressed that they did not get feedback about any action by the trust when concerns were raised with senior managers.
- Following the inspection, we have continued to have a number of concerns raised by staff. The majority of these relate to the culture and the response to staff raising concerns.
- The NHS staff survey (2015) showed the percentage of staff experiencing harassment, bullying or abuse from staff within last 12 months was below (better than) other acute trusts and the percentage of staff experiencing discrimination at work in last 12 months was in the lowest (best) 20% when compared

with other acute trusts. However, it also showed that the percentage of staff reporting most recent experience of harassment, bullying or abuse was worse (14% compared to 37%, where the higher score is better) than other acute trusts in England. This had deteriorated from the 2014 staff survey results and was in the worse 20% of trusts nationally.

- As part of the people plan, the trust was developing a guardian role to oversee any whistle blowers and support staff with raising concerns.
- The trust undertook a quarterly 'pulse check' for staff. Results from November 2015 showed 79.5% of staff agreed or agreed strongly that they would recommend the trust as a place to work. Only 6% and 2% answered 'disagree' and 'strongly disagree' respectively to the question about whether they would 'recommend my hospital/trust as a place to work.' This supported the findings of the NHS staff survey (2015) which showed the percentage of staff recommending the organisation as a place to work or receive treatment had increased and was better the average when compared to other acute trusts.

Fit and Proper Persons

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had a standard operating procedure in place for the Fit and Proper Person. This included all executive and non-executive directors.
- We reviewed the personnel files of the executive and two non-executive directors. We found the process for directors appointed after the introduction of the FPPR was fully compliant with the requirements.
- We found that all executive and non-executive directors had a Disclosure and Barring Scheme check including those employed prior to implementation of the FPPR with the exception of one director. The trust explained their rationale for this. However, following the inspection they undertook a DBS check with the staff member's permission.
- There was an annual declaration of ongoing compliance and clear procedures and checks for new applicants.

Public engagement

- The Director of Nursing was the executive lead for patient experience.

- A Patient & Public Experience & Engagement Strategy for 2016-2020 was approved by the board in January 2016. This outlined standards and expectations for delivery.
- The trust had an established patient and carers panel which reported to the trust's Patient and Public Engagement and Experience (PPEE) Steering Group. The panel was involved in a broad range of initiatives at the trust including 'you said, we did' projects.
- The trust collected real-time inpatient surveys. A team of volunteers visited the wards each morning to collect the data which was reported at meetings from ward to board level.
- The council of governors gathered patient feedback and this was reported in an annual report.
- Patients and the public had been involved in the planning and development of projects, such as the new emergency department unit, plans to redesign community services and the refurbishment of the outpatient department.
- Some wards displayed a "you said, we did" board and we saw examples of changes made as a result of the feedback.
- Wards displayed friends and family results and cards sent by patients and relatives.
- The trust completed a monthly carers audit to understand the hospital experience of people living with dementia.
- Volunteers had been trained to support patients with feeding, new mums with breastfeeding and as 'way finders' in outpatients.
- We saw examples of engagement across the organisation, for example in children's services, children and young people were encouraged to share their views on the children's unit by the use of a 'washing line'. The children and young people were encouraged to give their feedback by putting tops (positives) and pants (negatives) on the washing line and within community services patients were involved in focus groups to develop pathways of care.

Staff engagement

- The NHS staff survey (2015) found that the trust's staff engagement score was 3.8 which was average when compared with trusts of a similar type. This had increased from the 2014 staff survey results.
- The trust aimed to increase the number of staff who took part in the staff survey, which was at 40% in 2015. There had been some improvements in some areas including recommending the trust as a place of work and effective team working. There was an action plan in place to improve on the staff survey. We were told that in the 2014 staff survey the question over line

management was below average and that this had improved. Other areas where the trust had improved was the appraisal rates, although it was acknowledged that more was needed to be done to improve the quality of these.

- The Chief Executive told us how staff views were ascertained three to four times a year in the form of a 'pulse check'. In addition, feedback was also sought during conversations with staff during Executive Director listening sessions when they visited clinical areas to see what other actions could be taken to support staff. Part of the dashboard information to the Board included a measurement of staff morale.
- Within the critical care unit, Band 5, band 6 and other front line staff were not invited to monthly meetings by the matron. They told us that they were given information by band 7 staff on a need to know basis.

Innovation, improvement and sustainability

- The trust had an established telemedicine hub that provided services to nursing and residential care homes, prisons and patients at the end of life.
- The trust had recently been accepted as one of the two NHS England Vanguard sites in England to take part in 'The Serious Illness Care Program'. This was developing ways to train clinical staff to use a structured guide for advance care planning discussion with patients, and to prepare patients and families for the conversation.
- The trust were also part of the Airedale Partner's Enhanced Health in Care Homes Vanguard whose objective was to enhance the quality of life, and end of life experience of thousands of nursing and care home residents living in Bradford, Airedale, Wharfedale, Craven and East Lancashire.
- The medical management team had agreed with local partners the pilot of a complex care model based upon the American extensivist medicine model. This would preselect high users of the service and, by the GP and geriatrician completing complex geriatric assessments, aim to improve the patient experience and reduce hospital admissions.
- The trust had introduced 'Airedale Winter Champions' during 2015.These members of staff used a WhatsApp' tool , to promote the early identification of pressure points and enable problem-solving.
- In-situ simulation training was provided for clinical staff

Overview of ratings

Our ratings for Airedale General Hospital

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

Our ratings for Airedale NHS Foundation Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	☆ Outstanding	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community End of Life Care services	Good	Good	Good	Good	Good	Good
Overall Community	Good	Good	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostics.

Outstanding practice and areas for improvement

Outstanding practice

- Telemedicine services provided at the digital care hub were outstanding. The telemedicine service provided remote video consultations between Airedale staff and patients in their own homes, care homes and in prisons. This service was available 24 hours a day 365 days a year.
- The collaborative care teams in the community were an outstanding example of a multidisciplinary team working. The teams worked across acute and community services and in collaboration with other agencies to provide a responsive service for patients 24 hours a day, 7 days a week. The teams aimed to support patients in crisis to remain in their own homes and avoid unnecessary hospital admission as well as supporting early discharge from hospital.
- Within end of life care, there were innovative ways to ensure care was patient centred for example the Gold Line Service, and 'flags' on electronic records; when patients with additional needs were admitted at the end of life, specialist staff were alerted and could respond in a timely way.
- Through the use of an electronic record and an integration system, a shared record could be accessed securely by partners across all the care settings, including GPs, to obtain a tailored view of an individual's information.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- The trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- The trust must ensure that the remote telemetry monitoring of patients is safe and effective.
- The trust must review the governance arrangements and management of risks within critical care to ensure that arrangements for assessing, monitoring and improving the quality and safety of the service are effective.
- The trust must ensure review the effectiveness of controls and actions on the local and corporate risk register, particularly in medical care and children and young people's services.
- The trust must continue to improve engagement with staff and respond appropriately to concerns raised by staff.
- The trust must ensure that staff complete their mandatory training including safeguarding training.
- The trust must ensure that guidelines are up to date and meet national recommendations within NICE guidance or guidance from similar bodies.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must ensure the safe storage and administrations of medicines.
- The trust must improve compliance in medicines reconciliation.
- The trust must ensure records are stored and completed in line with professional standards, including an individualised care plan.
- The trust must ensure an effective system is in place to ensure that community paediatric letters are produced and communicated in a timely manner.
- The trust must ensure that resuscitation and emergency equipment including neonatal resuscitaires, is checked on a daily basis in line with trust guidelines.

Outstanding practice and areas for improvement

- The trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.
- The trust must ensure that were the responsibility for surgical patients is transferred to another person, the care of these patients is effectively communicated.
- The trust must ensure there are sufficient numbers of intensivists deployed in accordance with national guidance.
- The unit must ensure a minimum of 50% of nursing staff have a post registration qualifications in critical care.
- A multi-disciplinary clinical ward round within Intensive Care must take place every day, in accordance with national guidance, to share information and carry out timely interventions.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. How the regulation was not being met: Nurse staffing levels in many clinical areas were regularly below the planned number. This included critical care, medical care, surgery and children's services. Planned nurse staffing levels in critical care were below the levels recommended in national guidance. Medical staffing numbers did not meet national guidance in the emergency department and there were insufficient intensivists in critical care.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform. How the regulation was not being met: Within critical care, 54.3% of nursing staff had been appraised against a target of 80%. At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 38% of nursing staff.

This section is primarily information for the provider

Requirement notices

Mandatory training compliance did not meet the trust's target of 80% in several areas including medical care and surgery.

Level 2 and 3 adult and Level 3 children's safeguarding training compliance was below the trust target of 80%.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) Systems and processes must be established and operated effectively to: (2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services. How the regulation was not being met: Incidents of harm or risk of harm were reported inappropriately, meaning that some incidents were treated as less serious than they were. Following our inspection in March 2016, we were informed of a serious incident that had occurred on the critical care unit. A further unannounced inspection showed insufficient action had been taken to prevent recurrence.

This section is primarily information for the provider

Requirement notices

Within medical care, there was limited evidence of controls in place on both the local and corporate risk registers for risks that had been added to the register up to five years ago.

Within children's services, some risks identified on the risk register did not appear to have had sufficient action taken by management. Service leads did not identify issues such as the backlog of dictation, nurse staffing levels and out of date policies as high risk. Nurse staffing levels had not been identified as a risk on the risk register.

A number of clinical guidelines were out of date and did not meet recommendations by national bodies, such as NICE.

Records were not securely stored in some areas.

There was not an effective system in place to ensure that community paediatric letters were produced and communicated in a timely manner.

Where the responsibility of surgical patients was transferred to another person, this was not always effectively communicated.

A multi-disciplinary ward round did not take place daily on critical care in accordance with national guidance.

In critical care, frontline clinical staff had not had a staff meeting for at least two years and that it was difficult for them to share experience and have discussions with their manager about issues they were worried about, such as staffing levels, delays in discharges to the wards and the problems with telemetry monitoring.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) Care and treatment must be provided in a safe way for service users

How the regulation was not being met:

Patients on remote telemetry were not always safely monitored.

The escalation of patients in accordance with the early warning score procedure, was not always followed.

Medicines were not always managed appropriately. On three surgical wards controlled drug (CD) records had been amended and not signed as per good practice guidance. For example, corrections on stock levels were not signed and receipt quantities were not always recorded accurately. We observed on ward 13 that a bottle of out of date liquid CD had been administered to a patient on 22 occasions.

We found some intravenous fluids stored in open room in an unlocked cupboard on the labour ward.

Resuscitation and emergency equipment, including neonatal resuscitaires, was not checked daily in accordance with trust guidelines.

The five steps to safer surgery were not consistently applied in practice.