Care Quality Commission

Airedale NHS Foundation Trust

Airedale General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

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. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme. We had 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. We rated safe and well-led 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.

Our key findings were as follows:

- The hospital 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 hospital requires improvement and we have seen a 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 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 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.
- 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, staff's understanding and application was inconsistent. Risks were not always identified and where these were, there was not always sufficient assurance in place.
- 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 the Executive Assurance Group.

Summary of findings

- However, we also 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.
- Outcomes for patients were mostly the same as or better than the England average.
- We found that patients were assessed and supported with food and drink to meet their nutritional needs.
- A new emergency department had been built to meet the increase in patient numbers and new models of working. In eight of the last 12 months, the trust had exceeded the standard of 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival which was higher than the England average.
- 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:

- 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.
- 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.

Summary of findings

- 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 rounds within Critical Care must take place every day, in accordance with national guidance, to share information and carry out timely interventions.

In addition the trust should:

Urgent and emergency care

- The trust should review why the number of patients leaving without being seen is higher than national average, and take action to reduce this number.
- The trust should improve ambulance turnaround times.
- The trust should ensure all MAJAX equipment is checked regularly and is in date.
- The trust should review compliance with the infection prevention guidelines when administrating intravenous drugs.
- The trust should review the recording of the cleaning of the children's area including the toys.

Medical care

- The trust should consider performing a regular service specific mortality review and ensure actions are taken as a result of the review.
- The trust should display the full safety thermometer information to patients, visitors and staff.
- The trust should review the environment and capacity in the haematology and oncology day unit.

Surgery

- The trust should ensure patients receive timely pain relief.
- The trust should ensure staff have access to up to date policies and guidelines based on best practice.
- The trust should review ward rounds on the surgical areas to ensure patients are appropriately reviewed by senior doctors.

Critical care

- The trust should review implementation of the Guidelines for the Provision of Intensive Care Services (PICS) 2015 guidance.

Maternity and gynaecology

- The trust should consider developing a maternity and gynaecology strategy to give direction and achievable objectives to the department.
- The trust should consider safety briefings as part of daily communication with staff in maternity services.
- The trust should review the use of the 'scrub' midwife on the labour ward and staffing establishment in maternity using a standardised acuity tool.
- The trust should consider submitting and displaying data to the maternity safety thermometer.
- The trust should audit the compliance of MEOWS charts on the labour ward.
- The trust should have systems in place to ensure investigations, including root cause analyses, are completed in a timely manner and in line with national guidance.

Children and young people

- The trust should review the environment in the child development centre.

Summary of findings

- The trust should review the provision of food to children so each person's nutritional needs are met.

End of life care

- The trust should ensure that 'do not attempt cardiopulmonary resuscitation' decisions are always made in line with national guidance and legislation.
- The trust should review the route families take to the mortuary and work to improve the environment in the viewing room.
- The trust should review the mode of transport used for transferring deceased babies and small infants to mortuary.
- The trust should review infection prevention and control measures within the mortuary.
- The trust should review the staffing levels for specialist palliative care team doctors.
- The trust should review resilience around staffing in the mortuary.
- The trust should work to improve recorded preferred place of death.
- The trust should consider auditing the responsiveness of referrals to SPCT.
- The trust should improve engagement with Black and Minority Ethnic (BME) communities, to identify if the trust is meeting the needs of this group of patients at end of life.

Outpatients and diagnostics

- The trust should review shared learning from incidents and complaints regularly and to all groups of staff.
- The trust should review the use of clinical supervision in the outpatient department
- The trust should continue to address cancer waiting time targets.
- Outpatient services should consider regular team meetings.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	The new department had been built to meet the demand in the increase in patient numbers and new models of working. The trust was part of the West Yorkshire Association of Acute Trusts (WYAAT). As a collaborative, this informed and influenced commissioning both locally and regionally including decisions on new models of care. The department was part of a project, which joined up the health and social care information through an IT system that was accessed securely by partners across all the care settings. There were governance, risk management, quality measurements and processes in place to enhance patient outcomes and openness and transparency about safety was encouraged. Care provided reflected national and professional guidance and legislation. The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients. There was evidence of good multidisciplinary working. Staff had access to a community hub, which was a central point of access, for community services. Feedback from patients, relatives and carers was consistently positive. Patients' complaints were managed in line with trust policy and feedback was given to staff. Medical and nursing staffing levels and skill mix was planned in line with busy periods. The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department. The mean time to initial assessment for patients arriving by ambulance was 15 minutes between December 2015 and February 2016. In eight of the last 12 months, the trust had exceeded the standard of 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival which was higher than the England average. Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried

out by a clinician within 15 minutes of arrival or registration. Between July 2014 and October 2015, this target was met. Between October 2014 and November 2015 the trust was in the bottom (better) 20% of all trusts in England for numbers of delayed handovers.
However, we also saw evidence that the department did not always meet the planned nurse staffing numbers and medical staffing did not meet national guidance. The completion of nursing documentation was variable. The proportion of patients leaving before being seen was consistently worse than the England average.

Medical care (including older people's care)	**Requires improvement**		Nurse and healthcare support worker staffing levels were regularly below the planned number. Due to staffing levels, ward managers were needed to provide clinical care on the ward and did not have capacity to take the management time allocated for them to focus on management and administrative issues. Staff did not always check patients' observations in accordance with trust guidance and there was evidence of a lack of escalation of care in one third of the records reviewed. Some policies associated with clinical risk, for example, sepsis and non-invasive ventilation were out of date, or did not meet national recommendations. Morale varied across staff groups with themes being around staff shortages, working additional hours, no capacity to take meal breaks and the type of support received from senior managers. Some staff raised concerns regarding the style of leadership and management in the service. There was limited evidence of controls managers had put in place on both the local and corporate risk registers for risks that had been added to the register up to five years ago. However, staff understood their responsibilities to raise concerns and report incidents and nursing staff received feedback about incidents. Safeguarding systems were appropriate to keep patients safe. There was good multidisciplinary team working and staff demonstrated an understanding of consent, the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLs).

Summary of findings

Feedback from patients and relatives was positive and the service took into account the needs of different people when planning and delivering services. Staff assessed and managed patients' pain relief, nutrition and hydration.
The service participated in relevant local and national audits and monitored patient outcomes. The 92% referral to treatment time standard was met consistently. The trust and service strategy focused on patient pathways and flow and improved patient experience.

Surgery **Requires improvement**

We had concerns about the escalation process of deteriorating patients; systems used were not always effective.
There was inconsistency in the application of some systems, processes and standard operating procedures, including the five steps to safer surgery, to keep people safe, particularly with theatres.
Medicines were not always managed, stored and administered appropriately.
There were periods of understaffing across a number of clinical areas.
Communication by medical staff during surgical patient handover's was not effective, and from records we reviewed, we were unable to demonstrate effective review of orthopaedic patients by consultants.
Care and treatment did not always reference current evidence based guidance, standards or best practice and patients did not always receive adequate and timely pain relief. Learning from complaints was not always evident.
The surgical services management team and senior nursing team had recently had new appointments with positions, which required more time to develop and become fully effective. Ward managers were required to provide clinical care on the ward and did not have capacity to focus on management and administrative issues. We also had concerns over the support matrons offered ward managers and the confidence ward managers had in matrons within the group.
However, we also found that incidents were reported, investigated and lessons were learned.

Summary of findings

Wards and departments we visited were visually clean and there was evidence of compliance with infection control standards in most areas.
National performance targets were being met, except the referral to treatment times for some surgical specialties.
Surgical services group had a well-documented vision and strategy documents for use in surgical services group, however staff were not always able to articulate the vision and strategy on the wards and departments we visited.
The inspection team were impressed with the leadership and dedication from the manager and staff working on ward 9. The team working in this area had recently won a number of internal awards.
Joint community and acute hospital records improved communication between all teams involved in the patient's care.
Patients on the wards we visited appeared happy and the majority of patients we spoke with were positive about the care they received. We observed positive interaction between patients and staff.
Feedback from patients and relatives was positive.
We saw good evidence of effective multi-disciplinary team working with in the orthopaedic department. Staff working within orthopaedics were knowledgeable about the discharge arrangements for patients in different commissioning areas. Services were planned in a way to meet the needs of the local population and cancellation of operations prior to and on the day of operation was low.

Critical care **Requires improvement**

Nurse staffing levels for the unit consistently fell below safe levels, staff appraisal of their work performance was low and the number of staff trained on post registration training in critical care nursing was below the recommended minimum numbers. Staff were not allocated sufficient time to fulfil their specific roles such as the clinical nurse educator and the clinical coordinator. Staff were not assigned to carry out remote telemetry monitoring of patients and respond to arrhythmias in timely manner.

Summary of findings

We found that multidisciplinary ward rounds did not comply with national guidance and arrangements for medical staff handovers at shift changes were not formal.
Patients' notes were not all securely stored.
Patients well enough to leave the unit experienced delays and did not receive formal follow-up support once they had been discharged from the hospital.
Sharing of information between senior managers and the front line staff was not effective. When actions following audits had been required, there was a lack of monitoring of progress.
However, we also found that there was a designated consultant review of all new patients within 12 hours of admission. The unit was kept clean and visitors and staff had access to hand washing facilities to promote infection control. Priorities and values of staff underpinned their mission 'here to care'.
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 met with the Chief Executive to gain assurance that additional actions were taken to ensure safety.

Maternity and gynaecology

Good

The trust monitored and recorded patient outcomes on a monthly performance dashboard. Outcomes for patients that used the service were in line with national averages.
People were supported, treated with dignity and respect, and were involved in making decisions about their care. People spoke positively about the staff and felt supported and cared for.
Women's individual needs were taken into account in planning the level of support throughout their pregnancy. The service took account of complaints and concerns and implemented action to improve the quality of care.
We found effective governance arrangements were embedded and enabled the monitoring of risk. Performance and outcome data was monitored and reported monthly. Staff were encouraged to raise concerns and told us leaders were visible and accessible.

Summary of findings

We also found a lack of assurance around the consistency of checking of emergency equipment for adult and new born babies. The temperatures of refrigerators used for storing medication were not consistently monitored. Records showed that when temperatures were out of the recommended range for some of the refrigerators no action had been taken. Root cause analyses were not always completed in a timely manner. Mandatory training figures for the service was below the trust target of 80%.

Services for children and young people

Good

Staff were caring and showed compassion. Feedback received from patients and their families was positive.
The service had the presence of a paediatric consultant in the hospital 24 hours a day, seven days a week.
There were good examples of multidisciplinary teamwork and there were transition clinics in place for those with long term conditions.
Policies and protocols were based on national guidance, although a number were out of date. Staff contributed to audit programmes in order to determine compliance with guidance.
However, we also found that nursing and medical staffing levels did not meet nationally recommended guidance. No acuity tool was used to determine required staffing levels. At the time of inspection, there were excessive amounts of community paediatric medical records in an office waiting for dictation. The trust took action and provided information to the CQC on the progress.
There was not a robust system to ensure practitioners were having safeguarding supervision at the required frequency. There was no clear strategy for the children's services, although they had an annual plan.

End of life care

Good

There was seven day face to face specialist palliative care support available to patients and patients were assessed and care planned and delivered in line with evidence based guidance.
There was a commitment to good quality end of life care and staff were trained and demonstrated a consistently good knowledge of end of life care issues. Pain was well managed and patients were treated with compassion, dignity and respect. We

Summary of findings

consistently heard from staff that end of life care was prioritised based on patient need. Bereaved family and friends were cared for in a sensitive and supportive way by bereavement staff.

The Gold Standards Framework was in use throughout the hospital to support the development of good quality end of life care. Two wards had been successful in achieving an independently validated quality accreditation for the Gold Standards Framework.

We saw technology had been used to enhance the delivery of effective care through the use of an electronic palliative care coordination system. Patients were identified as being in the last year of life and the information was shared with professionals. There were innovative ways to ensure care was centred around patients, for example by use of 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.

There was positive multidisciplinary team work and a high standard of collaborative working internally in the hospital and also externally between the hospital and other services.

However, we also found that facilities for families and friends could be improved. These were not available on all wards and the route families walked to the mortuary was cluttered, shabby and unpleasant. There were several concerns about the mortuary. The viewing room used for families to see deceased patients was stark and basic. Mortuary staff did not always refer to deceased patients in a compassionate manner. There were risks to the continuity of the mortuary service; one staff member had been on call for three months with some resilience in place.

There was below the national minimum staffing requirements for hospital specialist palliative care doctors. Around 67% of patients did not have a recorded preference in 2015 for their preferred place of care.

Arrangements for monitoring standards and guidance for staff were poor. Most standards and guidance on the trust intranet were past their review date, some by several years.

Summary of findings

Do not attempt cardiopulmonary resuscitation decisions were not always made in line with national guidance and legislation.
There had been a lack of engagement Black and Minority Ethnic (BME) communities. This was a concern to the trust as they acknowledged it was difficult to identify if the trust was meeting the needs of this group of patients at end of life.

Outpatients and diagnostic imaging

Good

Incidents were reported and staff knew how to report incidents. All areas visited were clean and tidy. The environment was suitable and the required equipment was available. A managed equipment service was in place for diagnostic imaging.
Medicines were found to be managed securely, however there were issues identified with refrigerator temperatures and the reporting of temperature deviations to pharmacy. Staff were aware of how to report safeguarding concerns.
Protocols were available for use in diagnostic imaging and staff were aware of national guidance from the National Institute of Health and Care Excellence (NICE). Staff understood consent and could describe examples where they document consent.
Staff treated patients with dignity and respect at the services visited. Patients were involved in their care and treatment was discussed with them. Patient feedback from the services visited was mostly positive.
Non-admitted referral to treatment targets in outpatients were being met between December 2014 and November 2015. The referral to treatment for incomplete pathway standards were met from April 2015 until November 2015. Cancer waiting time targets were met between quarter 3 2013/2014 and quarter 2 2015/2016. Staff overall were positive about working in their departments.

Airedale General Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Airedale General Hospital

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

The main hospital site is Airedale General Hospital, which provides a range of acute services. 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.

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 consultant obstetrician, consultant physician, specialist nurses, midwives, nurse directors and expert by experience.

Detailed findings

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

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), NHS Improvement, 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.

Facts and data about Airedale General Hospital

The trust employed 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.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The emergency department at Airedale NHS Foundation Trust provides a 24-hour, seven-day a week service to the local population. In 2014/15, the trust had 53,746 emergency department attendances. This equates to an average of 147 patients per day. 21% of emergency department attendances between April 2015 and November 2015 were children aged zero to 16 years old. This has been a consistent percentage for the last three years.

Between April 2015 and August 2015, 21.8% of attendances resulted in an admission, which is similar to the England average of 21.7%. The proportion of attendances resulting in admission at this trust were higher than the national average between April 2014 and March 2015.

Between October 2014 and September 2015, patients attending the emergency department (ED) at the trust and leaving without being seen has fluctuated between 5.3% and 2.6% and had consistently been higher than the national average.

Due to the changing demand on emergency care services, a new department had been built to meet the increase of patient numbers and to support new models of working. This replaced the previous department at Airedale NHS foundation Trust. The new department opened in December 2014. The new department was larger, allowing extra floor space, increased storage facilities and additional cubicles. The emergency department was a designated trauma unit. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised within the emergency department and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department had a nearby open grassed area where the helicopter could land and a protocol was in place for the transfer of the patient into the emergency department.

Emergency department patients receive care and treatment in three main areas: 'minors', 'majors' and resuscitation bays. Self -presenting patients with minor illnesses or injuries were assessed and treated in the 'minors' bays. There were six bays that could be used for minors patients, these could be flexed to use as majors cubicles if needed. One was decorated for children but could be used for adults. There were 10 majors cubicles (two of which were decorated for children.) One of these cubicles had a toilet, which could be used for patients who need to be isolated due to an infection. One of these cubicles was specifically designed for patients with dementia. There were additional rooms, one set up for assessing and treating a patient with an eye injury and one suitable for the assessment of a patient with a mental health illness.

There was a waiting area for adults and a separate waiting room for children, which was divided into two areas, one for older children and one for younger children. Patients with a serious injury or illness, arrived by ambulance through a dedicated entrance. Patients

were assessed in an area with two assessment bays. There was a resuscitation room, near the ambulance entrance, which had four bays, one of which was equipped for children and one was equipped for patients who had sustained trauma. All four resuscitation bays could be used flexibly as needed.

In order to make our judgements we spoke with 13 patients, 13 carers and 29 staff from different disciplines including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice and viewed 21 sets of records. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

Summary of findings

We rated the emergency and urgent care service as good because:

- The new department had been built to meet the demand in the increase in patient numbers and new models of working.
- The trust was part of the West Yorkshire Association of Acute Trusts (WYAAT). As a collaborative, this informed and influenced commissioning both locally and regionally including decisions on new models of care.
- The department was part of a project, which joined up the health and social care information through an IT system that was accessed securely by partners across all the care settings.
- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes and openness and transparency about safety was encouraged. Care provided reflected national and professional guidance and legislation.
- The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients.
- There was evidence of good multidisciplinary working. Staff had access to a community hub, which was a central point of access, for community services.
- Feedback from patients, relatives and carers was consistently positive. Patients' complaints were managed in line with trust policy and feedback was given to staff.
- Medical and nursing staffing levels and skill mix was planned in line with busy periods. The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department.

Urgent and emergency services

- In eight of the last 12 months, the trust had exceeded the standard of 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival which was higher than the England average.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Between July 2014 and October 2015 this target was met. We also looked at data between December 2015 and February 2016 for patients arriving by ambulance and found the mean time to initial assessment was 15 minutes.
- Between October 2014 and November 2015 the trust was in the bottom (better) 20% of all trusts in England for numbers of delayed handovers.

However, we also found:

- The department did not always meet the planned nurse staffing numbers and medical staffing did not meet national guidance.
- The completion of nursing documentation was variable.
- The proportion of patients leaving before being seen was consistently worse than the England average.

Are urgent and emergency services safe?

Good

We rated the emergency department as good because:

- Openness and transparency about safety was encouraged and there was a strong culture of reporting incidents. Feedback and lessons learnt from incidents was shared amongst the staff.
- The department was visibly clean and we observed good hand hygiene.
- The new department had been built to meet the demand in the increase in patient numbers and new models of working, creating a spacious environment with separate paediatric facilities.
- The department used an electronic dispensing system for dispensing medicines which was accessed using finger print technology. This also provided an audit pathway and improved inventory control.
- The department was part of a project, which joined up the health and social care information through an IT system, that was accessed securely by partners across all the care settings.
- Care provided reflected national and professional guidance and legislation, and staff training was in place. Staff responded in a timely way to patients who showed signs of deterioration and had plans in place to deal with medical emergencies.
- Safeguarding vulnerable adults and children were given sufficient priority and there was active and appropriate engagement in local safeguarding procedures.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Between July 2014 and October 2015 this target was met.
- During the inspection, we observed the flow of patients and reviewed current information on waiting times. We observed the time patients waited in the waiting room. The longest the patients waited was 10 minutes.
- Medical and nursing staffing levels and skill mix was planned in line with busy periods. The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department.

- The department had taken part in a major incident exercise and staff were aware of their role in a major incident.

However:

- We saw evidence that the department did not always meet the planned nurse staffing numbers and medical staffing and children's nurse staffing did not meet national guidance.
- The completion of nursing documentation was variable.

Incidents

- There was a strong culture of reporting, investigating and learning from incidents.
- To report incidents, staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents.
- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. The department had no never events.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). Three serious incidents were reported to STEIS between February 2015 and January 2016.
- There were 219 incidents between 1st February 2015 and 31st January 2016. 211 (96%) of these incidents resulted in no or low harm. There were two unexpected deaths reported which were in February 2015 and January 2016.
- Following investigations of incidents of harm or risk of harm, staff told us they always received feedback. Learning from incidents was discussed and cascaded through several forums. Learning from incidents was discussed individually, displayed on a notice board in the staff area, discussed in the clinical governance group meetings. During handover, the department lead produced a safety brief, which included any learning from incidents to share with staff.
- Staff were aware of the statutory Duty of Candour principles. The department had a system in place to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Examples of duty of candour were given and we saw staff were open and honest with the patient and their family.
- Any unexpected deaths or potentially avoidable deaths that occurred in ED were reviewed within a medicine governance meeting.

Safety thermometer

- There were no pressure ulcers, no falls and no catheter associated new urinary tract infection attributable to the ED recorded via the Patient Safety Thermometer between September 2014 and September 2015.

Cleanliness, infection control and hygiene

- The emergency department was tidy and we saw cleaning in progress during the visit. Most of the equipment had 'I am clean' labels attached documenting the time and date when it was last cleaned.
- We reviewed areas including the sluice, administration stations and relatives waiting areas and found them clean and tidy.
- Needle sharp bins in the areas were not over full (more than ¾ full) and the bins were dated and signed by a member of staff, (as required by the trust's policy).
- Staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care.
- We observed medical and nursing staff following the trust policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were adequate hand washing facilities throughout the department and hand gel dispensers were available in each cubicle.
- In the CQC's 2014 A&E survey, the service scored 8 out of 10 for the question: "In your opinion, how clean was the A&E department?" This was about the same as other trusts.
- Hand hygiene was audited on a monthly basis. The audit results for April 2015 to November 2015 showed between 88% and 100% compliance.
- We viewed four cleaning audits from February 2015 to November 2015 and they scored between 92% to 99%.

- We found one commode which was dirty underneath. This was raised with a member of staff. When we checked the following day, it was still dirty.
- Staff did not routinely carry out mattress audits. We were told they were checked and cleaned between patients. On inspection, we checked six mattresses and found they were clean and they had no tears in them.
- The majors and minors areas had appropriate facilities for isolating patients with an infectious condition as all the cubicles were separate and one cubicle had a toilet in it.
- In the children's waiting areas, toys were visibly clean. There was no cleaning check list.
- The bays had a cleaning checklist in place and we saw these had been completed daily. Cleaning was allocated within the shift safety brief.
- Waste was managed in line with effective infection control practices.
- However, at January 2016, 62% of ED nursing staff had up to date training in infection control. The trust's internal target for this training was 80% by March 2016.

Environment and equipment

- Due to the changing demand on emergency care services, a new department had been built to meet the demand in the increase in patient numbers and new models of working. This replaced the existing department at Airedale NHS foundation trust, and the new department opened in December 2014.
- There were good paediatric facilities. A separate waiting area was split into two, one for older children and one for younger children.
- There was a resuscitation room, near the ambulance entrance, which had four bays, one of which was equipped for children and one was equipped for patients who had sustained trauma. All four resuscitation bays could be used flexibly as needed. The resuscitation area was visibly clean and well organised.
- The children's bay had an electronic tablet which doctors could access paediatric guidelines.
- The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner.
- Access to areas in the department was controlled by electronic card entry systems. Staff ID badges acted as their access control. This enabled the hospital to restrict access to sensitive areas to particular groups of staff. The card access system could be audited if required to show which staff had used their card to enter a specific area
- Equipment trolleys were labelled and matched with an equipment checklist. We saw evidence that these had regular checks.
- There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.
- Testing of electrical equipment had been carried out in the department. All equipment was serviced by the medical engineering department on a rolling programme basis. Stickers on the equipment confirmed servicing and maintenance had been completed.
- In the CQC's 2014 A&E survey, the service scored 9.7 out of 10 for the question: "While you were in the A&E Department, did you feel threatened by other patients or visitors?" This was about the same as other trusts.
- Security arrangements were in place 24 hours a day within the hospital. Closed circuit television (CCTV) was also in operation.

Medicines

- Staff followed systems that demonstrated compliance with legislation.
- The department used an electronic dispensing system for dispensing medicines which used finger print technology to control access and provided an audit pathway and improved inventory control. Staff told us they felt this system had improved patient safety.
- All intravenous infusions were stored in their original boxes or in appropriately labelled containers.
- A locked medicine fridge was part of the electronic dispensing system that meant the pharmacy department were automatically alerted if the temperature of the fridge was 'out of range'.
- Medical gases were stored safely in a separate area.
- Medicine prescribing was done on paper records.
- The department did use patient group directions. We viewed these on an electronic system and all were in date and signed by the nurses who used them in line with trust policy
- We observed patients were given a red wrist band if they had an allergy, to enable easy identification.
- We observed a member of staff administer intravenous antibiotics. Infection control guidelines were not

followed. For example, during the preparation of the intravenous drug, there was no washing of hands (alcohol gel was applied), the tray used to mix the drugs was not cleaned prior to use and no gloves or apron were worn. There was no cleaning of the cannula site before the medication was given. The nurse did not ask the patients name and date of birth.

- We reviewed seven paediatric and fourteen adult patient records and found that records showed medicines had been administered as prescribed and no prescribed medicines had been omitted.

Records

- Airedale NHS Foundation Trust were part of a project called the Integrated Digital Care Record Programme for Bradford, Airedale, Wharfedale and Craven, which aimed to make the district one of the first in England to join up the health and social care information. Information that was shared through the record included patient name, address, GP details and telephone number, diagnosis, medications, allergies, care referrals, clinic letters, discharge information and physical health reviews.
- Through the use of an electronic record system and an integration system, the shared record could be accessed securely by partners across all the care settings to obtain a tailored view of an individual patient's information.
- A paper copy of the record was sent to the ward when patients were admitted. For patients discharged directly from ED, the paper record was scanned onto the IT system. Once this had happened, the paper record was destroyed.
- A discharge letter was generated through the IT system to the GPs who used the same system; those who did not, received a copy in the post.
- Access to patients' previous notes was timely and could be accessed via the medical records department 24 hours, seven days a week.
- We initially reviewed 21 sets of patients' records fully and found completion of documentation was variable. For example, we could not tell if nursing care was actually given because the record of nursing care was inconsistent. We saw a check list known as an 'intentional rounding' document which prompted the nurses to ask if the patient was comfortable, and if they needed anything such as pain relief or food and drink. On checking seven patients notes who were over 75 years of age, this was completed in three out of seven patients notes. The assessment of pressure ulcers was documented in four out of the seven and a risk assessment for falls was documented in five out the seven over 75 year olds' notes.
- An audit had been carried out in March 2016 of the use the intentional rounding document. The findings were out of 10 records for patients over the age of 65 years, three had intentional rounding documented. An action plan was put in place as a result and a re-audit planned.
- We noted pain scores were not completed; therefore, we could not tell if patients were given timely pain relief.
- Writing was legible in 19 out of 21 patients' records, and they were dated and timed.
- The frequency and documentation of the recording of patients' observations was in line with best practice guidance in 19 out of the 21 sets of records.
- The recording of the patients' allergy status was not on one set of the paediatric records and two of the adult patient records that we checked. This increased the risk that patients may be given inappropriate medicines that could have a harmful effect.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit and arranged for safe storage of notes.

Safeguarding

- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- We reviewed seven children's records. All the children had been assessed regarding safeguarding.
- Staff said they knew how to recognise and report both adult and children safeguarding concerns.
- We observed staff accessing the trust safeguarding guidelines, which were readily available on the trust IT system. This provided information of how to make referrals when staff had concerns about a child or adults' safety.
- Any safeguarding concerns were escalated to the senior nurse and doctor.
- If a child had two or more attendances in 12 months, the doctors completed further information regarding safeguarding on the ED documentation and computer system

- There were safeguarding team for adults and children and a robust referral system in place. A paediatric liaison nurse worked in the ED three mornings each week and liaised with the local authority, school nurses and health visitors.
- We were told that there was a safeguarding audit every 3 months looking at completion of documentation.
- Staff were aware of the assessment for child exploitation and female genital mutilation (FGM). There was a FGM policy in place and this was easily accessible.
- The ED has a safeguarding meeting bi-monthly and there was a trust wide operational safeguarding meeting bi-monthly.
- Safeguarding training overall completion rate was 92.1% for adult safeguarding training and 76.3% for children safeguarding level 3 training. The trust's target completion rate was 80%.

Mandatory training

- There was a trust mandatory training policy in place which referenced 14 statutory training requirements, mandatory training requirements and training in essential skills. This included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act 2005 and the deprivation of liberty safeguards (DoLS).
- For each training element, staff groups were identified and the frequency of each training element. Employees had a personal training account, which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- The compliance rates for the trust were set at 80%. The department was 76.7% compliant with mandatory training. There was a plan in place to ensure that the department would be meeting the trust standard by March 2016.
- Staff completed most mandatory training using e-learning however, there were some clinical skills that resulted in competency based classroom sessions.
- Time was allocated in the off-duty for face to face mandatory training although staff did online learning in their own time or at work, if time was available.
- New staff received a corporate induction programme that included some face to face mandatory training.
- Consultants and junior doctors received training in paediatric life support and a paediatrician provided additional support. All senior doctors (middle grade and above) and senior nurses (band 6 and above) received advanced paediatric life support training.
- Training showed 82% of nursing staff had completed basic life support training.

Assessing and responding to patient risk

- A National Early Warning Score (NEWS) system for acutely ill patients was used, which supported the process for early recognition of those patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. We checked adult 21 records and 17 out of 21 had their NEWS recorded.
- Patients who walked into the department were registered by the receptionist and directed to the waiting room. They were then seen by nurses who undertook triage in a dedicated cubicle.
- Patients arriving by ambulance entered through a dedicated entrance specifically for ambulances. There were two bays available where patients had an initial assessment by a nurse. The initial assessment included commencing investigations that would assist with diagnosis and treatment. For example bloods were taken, electrocardiograms (ECG) carried out, analgesia prescribed and x-rays ordered. A nurse then triaged the patient into the appropriate area (unless the patient required immediate access to the resuscitation bay).
- The trust used a recognised triage system in the 'minors' area which categorised the severity of the patient's condition and level of risk. This reflected the order in which patients were seen.
- Once triaged, the walk in patients received an initial assessment by a doctor or nurse.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Between July 2014 and October 2015, this target was met.
- However during the inspection, the recent records we examined informed us that the target was met for nine out of 13 patients notes we checked who arrived by ambulance. These times were between 0 and 36 minutes. We looked at data between December 2015 and February 2016 and found the mean time to initial assessment was 15 minutes.

- We checked 16 patient's notes who had walked into the ED. They waited between four and 72 minutes for an initial assessment by the triage nurse. Ten of these patients were assessed by the triage nurse within 15 minutes.
- The emergency department was a designated trauma unit and provided care for all trauma patients. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised at Airedale General Hospital and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department was served with a nearby grassed area were the helicopter could land and a protocol was in place for the transfer of the patient into the emergency department.
- A handover process to the wards was used known as SBAR. (This is used to describe the patients' medical Situation, Background, Assessment and Recommendations). This allowed staff to communicate assertively and effectively, ensuring key information was passed to relevant staff and reducing the need for repetition.
- An escalation process was in place that gave staff actions for how to manage the department during periods of extreme pressure. This would involve help from the wider hospital teams, including bed managers and acute care team improving the patient flow throughout the hospital and specialist teams reviewing patients in the ED. The shift leader completes an escalation record that includes triggers for escalation.
- The trust performed 'about the same' as other trusts in the 2014 CQC A&E Survey questions for the three questions relating to assessing and responding to patient risk.

Nursing staffing

- The department completed a nurse staffing audit using a recognised workforce planning tool on four separate occasions between September 2014 to March 2015. This tool, developed by the Royal College of Nursing Emergency Care Association and Faculty of Emergency Nursing, was specifically for use in Emergency Departments to allow any disparity between nursing workload and staffing to be highlighted. The tool analysed the volume and pattern of nursing workload and tracked this against the rostered staffing level, calculating the whole time equivalent workforce and skill mix that would be required to provide the nursing care needed in the department during the audit period. The senior nurse team correlated the results, service demand and professional judgement to develop the staffing ratios.
- As a result of the audits, staffing levels were increased and matched with the busy times. Additional shifts were put in place such as a staggered start at 9.30am to 10pm, a twilight shift 11.30 pm to 12 midnight and a 'half –twilight' shift 6pm to 2.30am. An additional emergency care practitioner was rostered on duty at the weekend and Mondays, as these were the busier days for patients attending with minor injury and illnesses.
- 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%. The unqualified (healthcare support workers) filled shifts were between 64% and 109%. The middle or late shift was consistently unfilled. This was the extra registered nurse shift, which was incorporated as a result of the acuity audit, to deal more effectively with the initial assessment of patients and improve ambulance turnaround times. Recruitment to this had not at the time of the audit taken place.
- We reviewed four weeks off duty during the inspection between 15th February 2016 and 13th March 2016. We found 22 shifts were unfilled and 28 shifts were covered by bank or agency staff.
- During our unannounced inspection, we found they were two health care assistants short on the night shift, however, they had one extra on the evening shift.
- We were told the nursing vacancy rate was 1.65 WTE, (4.45%). The sickness rate during 2014 to 2015 was 2.5%.
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, we saw displayed for each shift the actual versus planned numbers of nursing staff on duty.
- The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the 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. However, the guidelines state in departments who cannot achieve this there should be a plan in place to achieve this, in addition to ensuring that nurses access more detailed education in the care of children and young people, to be able to offer advice and support to other staff. 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 department was overseen by a matron who provided managerial support, and clinical support when necessary.
- The department used bank and agency nurses. Often the same nurses were used, providing familiarity to the department and many of the bank nurses were substantive staff. We were told the agency nurses were experienced emergency department nurses.
- Nursing and medical handover occurred separately at the beginning of each shift and there was a board round when necessary, more often when the department was busy. A board round is a discussion with the multidisciplinary team regarding patients. We observed a handover by the medical team. This included the medical staff coming off duty and those coming on duty. We were told sometimes the nurse in charge would attend. The handover was documented and included discussions around number of patients in the department and waiting times, a handover of each patient, any issues that had occurred, any deaths and any shortfalls in nursing or medical staffing.

Medical staffing

- We examined the medical staffing rota and talked with consultants and junior doctors. Medical cover was patient demand driven so that at busy times there was more medical cover.
- Within the department 36% of the medical staff were of consultant grade; this was higher the England average of 23%. They also had a higher percentage of middle grade and registrars with 59% compared to 52% the England average. However, proportions of junior doctors were noticeably lower than the England average at 5% compared to 24% England average.
- 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.
- There were seven whole time equivalent (WTE) A&E consultants employed by the trust at the time of inspection, with an additional full-time consultant recruited. This is therefore, below the CEM recommendations.
- There were eight junior doctors (seven WTEs) and six middle grades (five and a quarter WTEs).
- Consultant rotas demonstrated that a consultant presence in the department was between 8am to 2am Monday and Tuesdays. The consultant was resident in the hospital (in an on call room) from 2am until 8am. This left two junior doctors in the department. This does not comply with CEM guidance that states a minimum of a middle grade doctor should be present in an ED.
- From Wednesday to Friday a consultant was present between 8am and 10pm
- On Saturday and Sundays there was consultant cover from 9am to 9pm. Outside these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available in the department other than Mondays and Tuesdays nights.
- We were told a business case had been agreed to provide consultant cover from 8am to 12 midnight. Recruitment was ongoing at the time of the inspection.
- A paediatric consultant provided paediatric cover if needed and was on site 24 hours a day, 7 days per week.

Major incident awareness and training

- The trust had a major incident policy; this was accessible to staff on the trust intranet.
- Staff had an understanding of their roles and responsibilities with regard to any major incidents.
- There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials. We did find some equipment in 'grab bags' had passed its expiry date.

Urgent and emergency services

- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- Staff had undertaken training and practice that included rehearsal in wearing the protective suits.
- A major incident exercise had taken place on 25 November 2014 whilst the new department was empty, prior to its opening. In total 128 people took part in the exercise. Of these, 75 were staff from Airedale NHS foundation trust with the remainder being staff from North West Ambulance Service, other acute trusts, clinical commissioning groups (CCG) s, medical students and volunteers. The scenario was specifically designed to rehearse the major incident response arrangements within the new ED, major incident plans and procedures, command and control arrangements and to meet the requirements of the Civil Contingencies Act. The feedback received from the participants demonstrated that all these objectives were achieved.
- Major incident training was mandatory.
- The department had a separate decontamination room, which was next to the ambulance entrance. This contained three showers, and had access from outside.
- Staff had received training on how to care for someone who may have symptoms of Ebola.
- The department could be locked down easily to ensure the safety of patients should the need arise

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the emergency department as good for effective because :

- Policies and procedures had been developed in conjunction with national guidance and best practice evidence.
- The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients.
- Staff were supported through a process of meaningful appraisal. A mentor supported new staff, and a supernumerary period of time was given that varied depending on their previous experience and learning needs. A clinical educator was in post.
- There was evidence of good multidisciplinary working. A 'frail elderly' team attended ED liaising with the community teams. Staff had access to a community hub, which was a central point of access, for community services.
- The department offered a 24-hour seven-day service however; some services were available out of hours as an on call service.
- Information was shared across health and social care, through the integrated IT system
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment

However:

- Documentation of pain scores and nutritional and hydration needs were not always completed.

Evidence-based care and treatment

- There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments.
- The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments.
- As a result of audit findings, we were told how the department improved pathways and guidance. For example, trauma network guidelines were up to date on the intranet, making them easily assessable and a trauma coordinator was in post.
- Care pathways had been established for conditions such as fractured neck of femur, and sepsis. These aimed to promote early treatment and improve patient outcomes. We saw evidence of the sepsis pathway being used in two of the patients notes we checked.
- Guidelines were easily accessible on the trust intranet page. There was a named person attached to each guideline who was responsible for updating the guideline. All the guidelines could be printed from the computer.

- Junior doctors were able to demonstrate ease of access to guidelines and found them clear and easy to use.
- The trust did not provide a designated hyper-acute stroke service. There were agreed pathways and protocols in place with a neighbouring trust and the ambulance service so patients picked up via ambulance were taken directly to the correct site. Patients who self-presented at Airedale Hospital ED with a suspected stroke had an initial CT scan prior to a discussion with the stroke on call team at the neighbouring trust to assess whether they needed transfer or admission to an Airedale hospital acute stroke bed.

Pain relief

- A pain score tool was used to assess if a patient had pain. Pain was scored as zero for no pain, up to 10 for severe pain.
- We reviewed 21 sets of adult patients' notes for the completion of pain scores. Only three records had documented the patient pain score. However, we did find evidence that pain relief was given on four of the 21 patient's prescription charts.
- Patients told us staff asked about their pain; nearly all of those patients who had pain said they were treated quickly. Patients were happy with the pain relief they had received.
- In the CQC's 2014 A&E survey, the service scored 6.3 out of 10 for the question: "How many minutes after you requested pain relief medication did it take before you got it?" and scored 7.2 out of 10 for the question: "Do you think that the hospital did everything they could to help control your pain?" Both scores were about same as for other trusts.

Nutrition and hydration

- Patients were offered food and drinks. Snack boxes were available 24 hours a day. Hot food was available from the hospital canteen if requested.
- There was no set mealtime regime.
- Patients told us they were offered food and drinks.
- We noted out of the 21 patients notes, seven had documented that food and/or drinks were given.
- Within the waiting room there were vending machines which contained cold and hot drinks, chocolate and crisps.
- Baby food could be accessed from the children's ward if needed.
- In the CQC's 2014 A&E survey, the service scored 5.9 out of 10 for the question: "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as other trusts.

Patient outcomes

- The RCEM has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimal clinical outcomes. The emergency department had participated in a number of audits to benchmark their performance against the CEM standards.
- Severe Sepsis and Septic Shock Audit was an audit of patients presenting to the emergency department with severe sepsis or septic shock in 2013 to 2014.The department performed in the lower quartile for three of the 12 indicators, between the upper and lower quartiles for seven indicators and in the upper quartile for the other two which were intravenous fluid bolus given in ED and antibiotics administered within an hour. Actions were put in place a result of the audit, which included an additional nurse with senior doctor leadership to help improve the initial assessment of patients and the measurement of early vital signs. A further sepsis audit was planned for April 2016.
- In the RCEM audit for asthma in children 2013 to 2014, the trust performed in the upper England quartile for seven out of the 10 indicators. They were in the lower quartile for two of the indicators during initial observations and in between the upper and lower quartile for intravenous prednisolone treatment. The additional nurse put in to help improve the timeliness of the initial assessment, was aimed at improving the trusts performance.
- In the initial management of the fitting child audit 2014 to 2015, the trust was performing between the upper and lower quartile for three out of the five indicators. It was in the upper quartile for recording eyewitness history and in the lower for managing the child according to the advanced paediatric life support guidelines or enhanced paediatric life support (EPLS) guidance. However, this was a small sample size.
- The mental health in ED audit 2014 to 2015 results were that the trust was performing between the upper and lower quartile for four out of the eight indicators. It was in the upper quartile for the remaining four. The actions

as a result included junior doctors teaching sessions and the department had moved into a new facility which provided a dedicated room for the assessment of patients with mental health issues.
- The audit for assessing for cognitive impairment in older people 2014 to 2015 showed the trust was performing in the upper England quartile for four out of six indicators and between the upper and lower England quartile for the remaining two indicators. The introduction of the initial assessment nurse would provide early measurement of vital signs and early warning scores.
- In the consultant sign off RCEM audit 2013, the trust performed between the upper and lower quartile for three out of four indicators. They performed in the upper England quartile for the indicator for consultant/ associate specialist discussing the patient.
- The department closely monitored its performance against a range of clinical indicators. This presented a detailed and balanced view of the care delivered by the emergency department. It also reflected the experience and safety of the patients and the effectiveness of the care they received.
- Action plans had been developed in relation to these audits, which were risk rated. For example, we viewed an action plan dated April 2015 which was as a response of a trauma peer review. Actions had included the ability to submit timely data to the Trauma and Audit Research Network (TARN) due to no coordinator. A coordinator had been appointed and was in place when we inspected.
- From October 2014 to September 2015 the unplanned re-attendance rate to the emergency department within seven days of discharge was consistently lower than the England average and fluctuated around the standard of 5%.

Competent staff

- Medical and nursing staff had an annual appraisal and staff spoke positively about the process.
- We were told 82% of nursing staff had received an appraisal.
- All medical staff had received an up to date appraisal (one had plans in place to receive one in the next few weeks)
- Senior nurses were responsible for undertaking their team appraisals.
- New nursing staff received a trust induction and trust wide competency based assessments for procedures such as venepuncture and administrating intravenous drugs.
- There was an emergency department introduction booklet which new staff worked through. A mentor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- A clinical educator was in post providing educational support to staff in the ED.

Multidisciplinary working

- We observed very good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency department. We observed doctors performing 'nursing' tasks and there was a good team approach to patient care.
- Care was delivered in a co-ordinated way using a number of different care pathways in place between the emergency department and the rest of the hospital. For example, ambulatory care pathways provided a seamless service from ED to the ambulatory care ward.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients if needed, for example palliative care nurses.
- The mental health team was based on the hospital site providing timely assessment to patients with mental health needs.
- A 'frail elderly' team which was a multi-disciplinary team attended ED six days each week (Monday to Saturday) from 7am to 6pm to review patients and support safe discharge, liaising with the community teams.
- Staff had access to a community hub, which was a central point of access, for community services.
- A GP out of hour's service was based in the hospital; links were being developed.

Seven-day services

- The emergency department had x-ray facilities within the department, which could be accessed 24 hours, seven days a week. CT scans were available within one hour. The department had an ultrasound available. If a patient required an MRI, it was available 24 hours, seven

days a week for a suspected metastatic cord compression; for other neurological conditions patients would be referred to a specialist neurological centre out of hours.
- There was availability of pharmacy and physiotherapy services seven days a week and 'out of hours' an on call service was provided.
- There was seven-day access to pathology services.

Access to information

- Airedale NHS Foundation Trust were part of a project called the Integrated Digital Care Record Programme (as discussed earlier in the report). Information was shared across health and social care, through the integrated IT system.
- A GP letter was generated from the IT system for GPs using the same system. This allowed GP's to access information on their patients quickly following an ED attendance. Other GP practices received a paper copy of a discharge letter.
- Patients' hospital notes were kept on site and were easily and quickly available from the medical records department.
- In the department, at the coordinators station, there were electronic screens that displayed the status and waiting times of all patients in the department.
- By using the trust's intranet, staff had access to relevant guidance and policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.
- Doctors gained written consent from patients who required sedation.
- Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment. Staff used Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children.

The 'Gillick Test' helps clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment

Are urgent and emergency services caring?

Good

We rated caring as good because:

- The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.
- Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in the decisions about their care and treatment.
- Care was person-centred and staff were observed to provide care which maintained the dignity and privacy

Compassionate care

- 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 questions: Did doctors or nurses talk to each other about you as if you weren't there?" and "Before you left the A&E Department, did you get the results of your tests?"
- In December 2015, the response rate for the A&E Friends and Family Test was 10.7% of which 95% of patients stated they would recommend the service to family and friends. In November 2015, the response rate was 13.7% of which 92% of patients stated they would recommend the service to family and friends. It has consistently been higher than the national average of between 87% and 88%

Urgent and emergency services

- We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed.
- We observed a number of interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach.
- In the CQC's 2014 A&E survey, the service scored 6.6 out of 10 for the question: "Were you given enough privacy when discussing your condition with the receptionist?" and scored 8.6 out of 10 for the question: "Were you given enough privacy when being examined or treated" Both scores were about same as for other trusts.
- We spoke with thirteen patients and thirteen carers. They were complementary of the staff. Comments included that staff were friendly, they treated patients with dignity and respect, and patients liked the spacious environment and felt safe. One patient commented that even though the department was busy, the space made it not feel chaotic.

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required.
- Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred

Emotional support

- There was a room for relatives to use if needed. Access to a telephone and drinks were available.
- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the multi-faith chaplaincy service.
- The spiritual needs of patients were provided by a 24-hour chaplaincy support that provided sacramental care in the trust chapel and at the bedside and through supporting patients at the end of life.
- We observed the hospital chaplain in the department offering support to patients and relatives.

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

Good

We rated the emergency department as good for responsive because:

- The service had systems and processes in place to facilitate the flow of patients through the department.
- In eight of the last 12 months the trust had exceeded the standard of 95% standard for emergency departments to admit, transfer or discharge patients within four hours of arrival which was higher than the England average.
- Between October 2014 and November 2015 the trust was in the bottom (better) 20% of all trusts in England for numbers of delayed handovers.
- The department had a specific 'dementia friendly' cubicle and there were processes in place for patients who presented with a learning disability or mental health problem.
- Patients' complaints were managed in line with trust policy and feedback was given to staff.

However, we also found:

- The proportion of patients leaving before being seen was consistently worse than the England average.

Service planning and delivery to meet the needs of local people

- Due to the changing demand on emergency care services, a new department had been built to meet the increase of patient numbers and to support new models of working.
- Additional cubicles and the flexibility of their use, allows a more effective use of the department.
- During our visit the department was not overcrowded and a sufficient number of treatment rooms and cubicles were available.
- Throughout the ED there were large boards in each area which gave patient information describing the patient journey through ED.

- The separate children's waiting room provided good segregation for children away from the adults waiting area. The children's room was split into two areas, one for older children and one for younger children.

Meeting people's individual needs

- The new department was larger allowing extra floor space, more storage facilities and more cubicles. It had 15 cubicles, which could be flexed for both 'minors' and 'major' patients. The minors cubicles had two access doors. One from the main central area and one from a small-seated area. This avoided patients going into the main area and provided privacy and confidentiality. There were additional cubicles. One was equipped for the use of patients with an ear, nose or throat injury. A suitable room for assessing patients with a mental health problem, and there was a cubicle dedicated for patients with dementia.
- Separate male, female and disabled toilets and baby change facilities were available in the waiting room. The department was accessible for people with limited mobility and people who used a wheelchair.
- The reception area had a designated hearing loop.
- Within the waiting room there were 42 seats and two vending machines which sold hot and cold drinks, plus snacks and a cold water machine. There were three large television screens displaying information on waiting times. One screen was a TV with sub titles and the sound was off. There was an information board with posters with contact details of support with drug or alcohol problems and details on how to contact the patient liaison advisory service information.
- A separate waiting area was split into two, one for older children and one for younger children, which had toys and books. A picture was projected onto the floor with moving balloons that younger children could chase. A sky scene was on one full wall with hot air balloons providing good visual stimuli. There were coloured benches, tables and chairs. There were cubicles that were used for children with minor and major illness or injury, which had colourful pictures.
- The electronic tablet in the resuscitation room used to access guidelines could also be used as distraction therapy for children as it had children's videos and TV programmes which could be played on it.
- The IT system had a flagging system. This included identifying patients with dementia or a learning disability.
- Staff told us if they had a patient with a learning disability they would encourage their carer to stay with the patient to help alleviate any anxieties and try and see the patient as soon as possible. A 'VIP' card had been introduced which contained medical and personal information which was used for patients with a learning disability. They used an assessment tool called 'closing the gap' which they were able to use to document patients likes and dislikes. During the time of inspection, we did not see a patient with a learning disability.
- There was a specific 'dementia friendly' cubicle. This had a TV screen which had a visual fish tank. Pictures on the wall were 'old scenes' and there was different altering lighting. The ceiling had an electronic picture and a clock on the wall with clear numbers to help patients distinguish between night and day. These changes were aimed at reducing anxiety. 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.
- We were told 'Twiddlemuffs' were available from the wards, which are knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached that patients with dementia can twiddle in their hands. Patients with dementia often have restless hands and like something to keep them occupied. The Twiddlemuffs provide a source of visual, tactile and sensory stimulation at the same time as keeping hands snug and warm. We did not see patients offered these.
- The 'Butterfly Scheme' was implemented, which at a glance created discreet identification via the Butterfly symbol for patients who had dementia-related memory impairment and wished staff to be aware of it.
- All the trolleys were able to be used for patients with a weight up to 306kgs. A hoist and bariatric wheelchair were available if needed.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only. We were told leaflets could be requested in different languages but they were not available immediately.
- Interpreting and translation services were available. These could be either face to face or by telephone.

Urgent and emergency services

- There was a relative's room and on request, relatives could access a telephone. Hot and cold drinks were offered and available on request. The relatives room was next to a viewing room for deceased patients providing direct access to people who wished to see their loved one.
- There was a mental health assessment room and the mental health team was based within hospital providing a service seven days a week 24 hours per day.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. In December 2015 94.3% of all patients were admitted, transferred or discharged within four hours of arrival to the emergency department compared to the England average of 91%. The trust had consistently been better than the England average except for June 2015 when it was 94.2% compared to 94.8%. In eight of the last 12 months the trust exceeded the standard of 95%.
- Between November 2014 and October 2015 the proportion of patients leaving before being seen was consistently worse than the England average. The percentage of patients leaving before being seen was highest in June 2015 at 5.3% and lowest in April 2015 at 2.6%.
- Between November 2014 and October 2015, the general median time to treatment was on average 69 minutes, which was worse than both the standard of 60 minutes and the England average of 53 minutes.
- 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 (better) 20% of all trusts in England for numbers of delayed handovers.
- 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.
- In the CQC's 2014 A&E survey, the service scored 8.3 out of 10 for the question: "Overall, how long did your visit to the A&E Department last?" This was better than other trusts.
- Between June 2014 and May 2015, there were on average 320 ambulance journeys per month with a turnaround of between 30 and 60 minutes and 12 journeys with a turnaround of over 60 minutes. Between 21% and 31% of ambulance journeys had a turnaround time of over 30 minutes each month.
- 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. These were in May 2015, June 2015 and November 2015. For May and June the reason was that there was no clinical staff available to take handover due to high activity in the department at that time, and in November it was due to all cubicles being in use at that time.
- During the inspection, we observed flow of patients and reviewed current information on waiting times. We observed the time patients waited in the waiting room. The longest the patients waited was 10 minutes.
- We observed ambulance handovers. There were no delays in ambulance handover times during our visit.
- We reviewed the notes for 12 patients who had arrived by ambulance. Time to initial assessment was between zero and fourteen minutes. Some data (seven) we were unable to interpret as the time on the ambulance handover sheet differed from the time of arrival to hospital on the hospital system.
- We observed the flow of children who had attended the department. We reviewed seven children's notes, which showed they were assessed between four and 27 minutes; the average time was 15 minutes.
- The bed management team observed flow within the emergency department and meetings took place at least twice a day (more frequently if needed) to understand the bed situation to enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- There was an escalation policy. This provided guidance on when and how to implement the escalation policy, to ensure safe working when the department was full or the hospital bed state was preventing flow of patients through the department.

- Patients who were referred by their GP with a medical problem, went straight the acute medical unit for assessment, this reduced the number of patients attending ED.

Learning from complaints and concerns

- The department had a complaints response process that addressed both formal and informal complaints, which were raised via the Patient Advocacy and Liaison Service (PALS). Formal complaints involved the general manager. Informal (PALS) complaints the matron discussed with the concerned patient/family as soon as possible after receiving the call with the aim of rapid resolution of the problem. All complaints were answered fully with an assessment of root causes made.
- Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.
- There were 11 complaints made between December 2014 to December 2015. The themes of these were related to staff attitude and communication to patients regarding their care and treatment.
- Staff told us they were aware of how to deal with complaints and they received feedback.
- Learning from complaints was discussed individually, displayed on a notice board in the staff area, discussed in the clinical governance group meetings. During handover, the department lead produced a safety brief, which included any learning from complaints to share with staff.
- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with complained about the department.

Are urgent and emergency services well-led?

Good

We rated well led in the emergency department as good because:

- Staff were engaged in the vision and the two year plan.
- The trust was part of the West Yorkshire Association of Acute Trusts (WYAAT). As a collaborative, it will inform and influence commissioning both locally and regionally including decisions on new models of care
- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes.
- The emergency department had a clear management structure at both directorate and departmental level.
- Staff described the culture within the service as open and transparent. Staff told us it was a good place to work
- The department demonstrated areas of innovative practice.

Vision and strategy for this service

- The emergency department was part of the medical services directorate.
- The trust had a 'Right Care' vision. The majority of staff understood the vision and it was well presented around the trust
- There was a two year plan for 2015 to 2017, which senior management told us included a new build to co-locate the medical unit within ED and provide an acute care hub.
- Airedale NHS foundation trust is part of the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT is a collaboration of West Yorkshire Acute Hospitals that has been established to provide a collaborative leadership forum between trusts to underpin the design, delivery, and operational effectiveness of acute services across West Yorkshire in the context of reshaping healthcare. As a collaborative, one of the aims is to inform and influence commissioning both locally and regionally including decisions on new models of care
- Development of the workforce and looking at the core competencies of staff was part of the role of the dedicated clinical educator for the medical directorate.

Governance, risk management and quality measurement

- A governance system was in place and the agenda items of the emergency department clinical governance group meetings included discussions of incidents, complaints and lessons to be learnt.

Urgent and emergency services

- A monthly emergency department business meeting took place that discussed finance, performance data, and workforce planning.
- Staff were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. Both these meetings reported into the medical group meetings and then into the integrated service meetings.
- The department risk register was available and was continually under review to ensure it reflected current risks relevant to the operational effectiveness of the department. Seven risks were recorded on the register at the time of our inspection. Each risk was graded, dependent on severity. There were two which were flagged at red risks (score of 10). One was regarding staff from ED being moved to cover shortages in other areas of the hospital and the other was the threat of violence or abuse towards staff in ED. All risks had an action plan to alleviate the risk the risks on the risk register did not match the risks identifies in the inspection for example nurse staffing was not on the ED risk register.
- When we spoke with the senior management team, they were able to clearly tell us about the risks posed to the department and how these were being addressed. For example, relating to the recruitment of medical and nursing staffing.
- We saw evidence of the emergency department being discussed in board level minutes.
- The department took part in RCEM audits and other locally agreed audits.
- The department had a clinical quality indicators dashboard.

Leadership of service

- The emergency department had a clear management structure at both directorate and departmental level.
- There was a clinical director, a matron and lead nurse who provided nursing and medical leadership.
- The nursing team was established with experienced staff who provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability.
- The medical team had responsibility for audits in the department. Staff told us there was a strong educational resource provided by the senior doctors.
- From our discussions with staff, the local leadership was strong, supportive and staff felt they were listened to and felt valued. However, they did not always feel listened to be senior trust managers.
- Staff were motivated and described a supportive team-working environment
- Staff commented that the matron was visible; some were unsure who the senior management team were within the hospital

Culture within the service

- Staff described the culture within the service as open and transparent.
- Staff told us it was a good place to work. They felt supported in their work and there were opportunities to develop their skills and competencies which were encouraged by senior staff. There was a desire from all staff we spoke with to provide effective care and treatment to patient
- We observed staff working well together and there were positive working relationships with the multidisciplinary teams
- We observed staff being flexible and helping in the different parts of the department which were busy to provide a better and more responsive service for patients

Public and staff engagement

- Senior management told us that staff, patients and the public had been involved in the planning and development of the new unit.
- We saw evidence that the service was active in seeking feedback from patients and relatives. There was an IT facility for patients in the waiting room to provide feedback through the friends and family test.

Innovation, improvement and sustainability

- Airedale NHS Foundation Trust were part of a project called the Integrated Digital Care Record Programme for Bradford, Airedale, Wharfedale and Craven, which aims to make the district one of the first in England to join up the health and social care information.
- Through the use of an electronic record and an integration system, the shared record can be accessed securely by partners across all the care settings to obtain a tailored view of an individual's information.

- The use of nitrous oxide as a sedation and analgesic was introduced for the use in children to reduce distress during painful procedures.
- An electronic tablet was used in the paediatric bay of the resuscitation room. This had guidelines for staff, but also could be used as a distraction therapy for children undergoing treatments as it contains a collection of children's TV programmes.

Medical care (including older people's care)

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

Information about the service

Medical care services at Airedale General Hospital were managed in the Integrated Care and Diagnostic Services directorate. There were 177 inpatient medical beds across nine wards and there were 12,817 medical admissions between December 2014 and November 2015.

We visited the following medical wards; ward 1 (ambulatory care unit and short stay ward), ward 2 (acute medical unit), ward 4 (care of the elderly), ward 5 (stroke and neurology rehabilitation), ward 6 (gastroenterology, endocrinology and care of the elderly), ward 7 (cardiology and respiratory), ward 10 (winter ward), the endoscopy unit (ward 8), the coronary care unit (ward 16) and the haematology and oncology day unit.

We spoke with 26 patients, five relatives and 45 members of staff. We observed care being delivered on the wards, looked at 22 patient records and 25 medication charts. We observed nursing handovers. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Summary of findings

We rated medical care as requires improvement because:

Nurse and healthcare support worker staffing levels were regularly below the planned number. Due to staffing levels, ward managers were needed to provide clinical care on the ward and did not have capacity to take the management time allocated for them to focus on management and administrative issues.

Staff did not always check patients' observations in accordance with trust guidance and there was evidence of a lack of escalation of care in one third of the records reviewed. Some policies associated with clinical risk, for example, sepsis and non-invasive ventilation were out of date, or did not meet national recommendations.

Morale varied across staff groups with themes being around staff shortages, working additional hours, no capacity to take meal breaks and the type of support received from senior managers. Some staff raised concerns regarding the style of leadership and management in the service.

There was limited evidence of controls managers had put in place on both the local and corporate risk registers for risks that had been added to the register up to five years ago.

However, staff understood their responsibilities to raise concerns and report incidents and nursing staff received feedback about incidents. Safeguarding systems were

Medical care (including older people's care)

appropriate to keep patients safe. There was good multidisciplinary team working and staff demonstrated an understanding of consent, the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLs).

Feedback from patients and relatives was positive and the service took into account the needs of different people when planning and delivering services. Staff assessed and managed patients' pain relief, nutrition and hydration.

The service participated in relevant local and national audits and monitored patient outcomes. The 92% referral to treatment time standard was met consistently. The trust and service strategy focused on patient pathways and flow and improved patient experience.

Are medical care services safe?

Requires improvement

We rated the service as requires improvement for safe because:

- Registered nurse and healthcare support worker staffing was below the planned levels up to 76% of the time.
- Staff did not carry out observations or escalate NEWS scores in line with trust guidance in one third of the 46 observation charts reviewed.
- The service did not have appropriate systems to ensure that medicines were handled safely and stored securely.
- Compliance with mandatory training in the service was below the trust target.
- All the wards we visited appeared cluttered with limited room for storage of equipment and there was high level dust throughout.

However, we also found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Nursing staff received feedback about incidents through a safety briefing and ward newsletters.
- Systems and processes for safeguarding were reliable and appropriate to keep patients safe

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There were no never events reported in the service between February 2015 and January 2016.
- Serious incidents are incidents that require further investigation and reporting. There were 15 serious incidents reported in the service between February 2015 and January 2016. Pressure ulcers and falls were the most frequent serious incidents. There had been eight pressure ulcers and four falls reported.
- Patients that required cardiac monitoring (telemetry) were admitted to specific wards and their telemetry was monitored remotely by staff on the critical care unit. A serious incident related to telemetry occurred in

December 2015 and the interim investigation report stated the senior management team would reinforce the telemetry protocol and ensure it was accessible to all staff. During our unannounced responsive inspection on 11 May 2016 staff told us of another incident that had occurred related to telemetry. The two incidents had common themes which suggested that the learning from the serious incident had not been embedded in practice.

- The trust investigated serious incidents using a root cause analysis process. We reviewed six investigations that all identified the root cause, lessons learnt, recommendations, a timed action plan and arrangements for shared learning.
- There were 1400 incidents reported in the service between February 2015 and January 2016, 70% were classified as no harm, 28% as low harm and 2% as moderate harm. The most frequent incident that was reported was a patient accident.
- Staff understood how to report incidents using the electronic reporting system.
- Staff received feedback about incidents and gave us examples of themes of incidents and changes that had been implemented, for example, the introduction of non-slip socks and staff based at satellite nurses stations to reduce falls.
- Ward managers discussed incidents and investigations at a sister's operational meeting and the learning from incidents was shared across teams through a safety briefing held at every handover and ward newsletters.
- Junior doctors were unable to tell us of any themes of incidents across the service. They told us they received feedback following incidents if they were directly involved in them or if they were discussed during teaching. There was no evidence of a structured process to share incidents and lessons learnt with junior medical staff. However, the postgraduate placement manager sent a regular quality and safety bulletin and learning for improvement newsletters centred around learning from specific serious incidents to junior doctors by email.
- We reviewed three sets of minutes from the mortality audit meeting over the last nine months. These meetings were not service specific and had limited attendance. We did not see evidence of robust actions as a result of the mortality review. However, we were told that prior to the meeting a multidisciplinary mortality reviewer completed a nationally recognised standardised tool to highlight any concerns or contributory factors to an unavoidable death. The mortality group produced an annual report highlighting themes and learning.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust included the process for Duty of Candour in the Being Open policy.
- Staff were aware of the importance of being open and honest with patients and their relatives and the need to apologise if there had been a mistake in their care.
- Ward managers were able to describe specific incidents they had been involved in and the actions they had taken to meet the requirements of the Duty of Candour.
- The quality and safety team provided an overview of the key steps to the Duty of Candour as part of staff's mandatory training.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Wards displayed the number of pressure ulcers and falls in the clinical area. They did not display the full safety thermometer information including CUTI, VTE. This meant staff, patients and relatives could not see the amount of harm free care that was provided.
- In the reporting period September 2014 to September 2015, the service reported 96 incidents of harm. Forty four pressure ulcers, 29 falls with harm and 23 CUTIs. The incidence of harm had reduced over time.

Cleanliness, infection control and hygiene

- All wards and areas we visited had high level dust throughout. Most sluice areas appeared clean and tidy.
- Clinical areas displayed infection prevention and control information visible to patients and visitors. Visitors had access to handwashing facilities, hand gel and personal protective equipment on entering the ward or side room.

- Information submitted by the trust showed there had been no episodes of Methicillin resistant Staphylococcus aureus (MRSA) in the service between March and November 2015.
- Information submitted by the trust showed there had been three episodes of Clostridium difficile (C.difficile) in the service between March and November 2015.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Staff told us they flushed water systems daily, however, they did not keep records for this. This meant there was no assurance it was completed.
- Information submitted by the trust showed 67% of nursing staff and 60% of medical staff had completed infection control training. This was lower than the trust target of 80%.
- Wards completed monthly hand hygiene audits and achieved the trust target of compliance between five and 11 times from November 2014 to November 2015.
- The trust completed an audit of catheter care and peripheral intravenous cannula care in November 2015. The service achieved 100% compliance in catheter care and 95% compliance in cannula care.
- Equipment was labelled as being clean. The label contained the date it had been cleaned on.

Environment and equipment

- All the wards we visited appeared cluttered with limited room for storage of equipment such as hoists, chairs, and mattresses the trust had a central mattress store and therefore wards were not expected to store mattresses in their area.
- The environment in the haematology and oncology day unit posed a risk of falls for patients and staff due to increased demand and lack of space. Drip stands that were in use with one patient were in front of an adjacent patient's chair. The chairs were touching each other and of different heights.
- Resuscitation equipment was available on all wards. Staff checked the resuscitation equipment daily and records for this were complete. The resuscitation trolley on ward 2 was not accessible in an emergency; it was stored in the patient lounge and blocked by other equipment. Staff addressed this immediately.
- Wards kept records of daily checks on oxygen and suction. Two of the three wards we checked had significant gaps in these records of between 10 and 50 days in three months.
- We checked 19 pieces of equipment, for example, observation machines, hoists and consumables on the wards; they had all been appropriately tested and were within their service/expiration date.

Medicines

- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Medicines records were completed using an Electronic Prescribing and Medicines Administration (EPMA) system. We reviewed 25 records all of which were complete.
- Medicines were not always stored appropriately on receipt from the pharmacy department. On wards 6 and 10 the pharmacy team used a deliveries box to deliver dispensed medication to the ward. Staff told us this box should be emptied daily. On ward 6, we saw medication for a patient on the ward that had been dispensed five days prior to our inspection was still in the deliveries box. The medication record showed this patient had missed a dose of medication due to "drug unavailable". This box also contained patients own medicines for a patient who was deceased, loose unlabelled medication and an anticoagulation record book for a patient who had been discharged.
- The service reported 213 medication errors between December 2014 and December 2015. This was 41% of all medication errors reported in the trust.
- On three wards there were gaps in the medicines fridge temperature records. This was not in line with trust policy and meant that drugs may not have been stored correctly. Three wards had out of date medication in the fridges, for example, we saw two items of expired medication in the fridge on ward 2; these were removed during our inspection.
- On one ward we found medication stored unlocked and unsupervised on the bottom of the medication trolley.
- Medicines were not always transferred with a patient when they moved ward or to another care environment. For example, we saw controlled drugs brought into the hospital by a patient had not been transferred from ward 2 when they moved to another ward. Patients own

medicines are their property and should be transferred with them unless there is documentation to state otherwise. We also saw medicines in the fridge on ward 2 for seven patients who were no longer on the ward and medicines in the fridge on ward 10 for four patients who were no longer on the ward. These medicines included insulin.

- National Institute of Clinical Excellence (NICE) guidance recommends in an acute setting, medicines reconciliation is carried out within 24hrs. The trust submitted a trustwide medicines reconciliation audit from December 2015 that showed the trust did not meet the NICE guidance for 53.4% of patients.
- Staff showed us the discharge checklist. This did not include any reference to if a patient brought their own medicines to hospital with them or if fridge items or controlled drugs were supplied on discharge. The trust medicines safety group meeting log included incidents about patients who had been discharged with the wrong insulin, suggesting the discharge process for medicines was not robust.
- An internal key performance indicator in the pharmacy department was for 80% of non-complex discharge prescriptions to be completed within one hour of receipt into pharmacy. Results of a trust-wide audit showed between 55% - 64% compliance with this indicator.
- We saw documentation that showed delays in obtaining medicines from the pharmacy department. Staff told us there were sometimes delays of up to 48 hours and this was worse at the weekend. There was a reduced pharmacy provision over the weekend period and no formal clinical pharmacy service to wards at the weekends.
- The ward manager on ward 2 completed a spot audit on three occasions in June and July 2015 of how quickly staff administered once only medication. The results showed that the medication was given longer than an hour after it was due between 6% and 33% of the time.

Records

- Records were not stored securely; on all the wards we visited medical notes were kept in unlocked trolleys on the corridor. Staff were not always present near the trolleys as they were attending to patient's needs.
- We reviewed 22 sets of records. The content of four of them was accurate, complete and in line with professional Nursing and Midwifery Council standards. None of the records we reviewed met General Medical Council guidance on keeping records as medical staff did not record their GMC number. Of the other records we reviewed, components of professional and trust standards were missing, for example, evidence of the name and grade of staff, diagnosis and management plan, daily review by a senior clinician or an individualised care plan.
- We reviewed one prescription for a patient who had received non-invasive ventilation (NIV) on ward 7. This was incomplete, with the escalation of therapy and discontinuation of NIV sections both blank.
- Matrons completed documentation audits to assess the quality and standard of the completion of records. Information submitted by the trust showed detailed results for November 2015 and did not have an overall summary or action plan for the service.
- Information governance training was included as part of the mandatory training programme. Information submitted by the trust showed 75% of staff had completed this training. This was lower than the trust target of 80%.

Safeguarding

- All staff we spoke to were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding lead.
- Wards displayed posters showing the safeguarding adults referral process as a step by step guide for staff.
- Information submitted by the trust showed 93% of nursing staff and 81% of medical staff in the service had completed safeguarding adults training. This was above the trust target of 80%.
- Information submitted by the trust showed 81% of nursing staff and 73% of medical staff in the service had completed safeguarding children training. Medical staff's training was below the trust target of 80%.

Mandatory training

- The trust had a comprehensive package of mandatory training for staff. This included modules on topics such as basic life support, moving and handling, equality and diversity and health and safety.
- Staff told us they were given time to attend mandatory training, if they completed it in their own time they were given the time back.

- Information submitted by the trust showed that overall compliance with mandatory training in the service was 73% for nursing staff and 66% for medical staff. This was below the trust target of 80%.

Assessing and responding to patient risk

- The trust used a national early warning score (NEWS) which indicated when a patient's condition may be deteriorating.
- We reviewed 46 observation charts and found that the NEWS scores were completed 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.
- 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.
- Observations for patients on non-invasive ventilation were not completed in line with the recommendations from the trust's NIV flowchart for acidotic exacerbations of COPD.
- 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 NIV and patients who had invasive lines, for example central venous catheters and peripherally inserted central catheters.
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. In the 22 records we reviewed most of the risk assessments were complete, only two nutritional risk assessments were incomplete. When the assessment had been completed and risks were noted, staff had completed appropriate care plans.
- In the haematology and oncology day unit every chair did not have a call buzzer. However, a nurse was based in the room at all times. Piped suction and oxygen was available in two of the treatment rooms. In the main communal treatment area staff used portable supplies

Nursing staffing

- The trust used the safer nursing care tool as recommended by the National Institute of Clinical Excellence (NICE), in conjunction with professional judgement and Royal College of Nursing guidelines to calculate safe nurse staffing levels based on patients' level of sickness and dependency.
- Nurse staffing levels were on the local and corporate risk register and there was an action plan to reduce the risk. Actions included twice weekly rota planning meetings and discussions about staffing at the bed meetings.
- Wards displayed the planned and actual staffing figures. During our inspection, the actual number of staff on duty were lower than the planned number of staff on most of the wards we visited. Senior staff told us they followed the staffing escalation plan.
- 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 68% of the shifts on ward 2 and 76% of the shifts on ward 10. The number of healthcare support workers on a day shift was under the planned number 22% of the shifts on ward 2 and 47% of the shifts on ward 10.
- We reviewed 10 weeks of nurse staffing rotas for a further three wards; the number of registered nurses on a day shift was under the planned number 7% of the shifts on ward 4, 46% of the shifts on ward 6 and 38% of the shifts on ward 7. The number of healthcare support workers on a day shift was under the planned number 11% of the shifts on ward 4, 34% of the shifts on ward 6 and 41% of the shifts on ward 7.
- Information submitted by the trust of nurse staffing rotas and number of beds open between December 2014 and March 2015, 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. Staff were moved between wards to cover gaps, however, most shifts were still short staffed and staff finished late. The nurse in charge of the ward escalated staffing concerns on each shift to the medical bleep holder. The medical bleep holder escalated these concerns to the relevant matron in hours and to the on call manager out of hours in line with the trust's nurse staffing escalation plan.
- We observed an off duty meeting which took place three times a week and was attended by ward managers.

From the discussion at this meeting, it was evident all wards were short of staff, ward managers moved staff to mitigate the risk and escalated their staffing concerns three times daily to the matron and the bed meeting.

- During our inspection the trust experienced the busiest week of the year so far. Most of the wards we visited during the inspection appeared disorganised, busy and at times, patients told us the staff were busy and worked hard.
- Staff told us they regularly worked with bank and agency staff, or trust staff who were not usually based on that ward. Information submitted by the trust showed that nursing bank and agency staff usage was between 0% - 76% in the service from April 2014 to March 2015.
- Information submitted by the trust showed wards in the service had 22.5 whole-time equivalent (WTE) nursing vacancies from their 134.77 WTE establishment and 2 WTE healthcare support worker vacancies from their 92.65 WTE establishment. All wards displayed current vacancy figures.
- All wards displayed unplanned absence figures. Sickness in the service was on average 5.3% which was higher than the trust target of 3.5%. Ward managers told us they felt supported to manage sickness with support from human resources.
- We observed a nursing handover on two wards where clear information was provided and plans were made for investigations, tests and procedures. Staff completed and updated an electronic handover document. The safety briefing was included in the handovers.
- Following the inspection we reviewed nurse staffing on four wards for the month of April 2016. The number of registered nurses on a day shift was under the planned number 63% of the time on ward 2, 63% of the time on ward 4, 37% of the time on ward 6 and 27% of the time on ward 7. This showed there had been little improvement in nurse staffing on the wards. As part of the staffing escalation plan and to mitigate risk to patient care additional healthcare support workers worked on the wards. The number of healthcare workers on day shifts was more than the planned number 17% of the time on ward 2, 83% of the time on ward 4, 3% of the time on ward 6 and 23% of the time on ward 7.

Medical staffing

- The medical staffing for the service was made up of 40% consultants, 6% middle grade, 22% registrars and 31% junior doctors. The percentage of consultants and junior doctors was higher than the England average and the percentage of registrars was lower than the England average.
- The acute medical unit (ward 2) had a total of 17 hours a day on site consultant time Monday to Friday. The cover was provided by three consultants on a rolling rota between 8am to 9pm. Between 9pm and 8am one consultant was on call but not always on site.
- The acute medical unit (ward 2) had a total of 18 hours a day on site consultant time on Saturday and Sunday. The cover provided by three consultants who were on site between 8am and 12pm and 3pm and 9pm. Between 9pm and 8am one consultant was on call but not always on site.
- The ambulatory care unit (ward 1) was staffed by one consultant and two junior doctors from 8am and 6pm and one advanced care practitioner from 8:30am to 9pm Monday to Friday.
- One registrar and two junior doctors provided medical cover on site at night. They were part of the hospital at night team, supported by advanced care practitioners, the acute care team and a healthcare support worker. The hospital at night coordinator allocated tasks from wards to the team using an electronic system.
- Consultants carried out at least three ward rounds a week; senior medical staff reviewed patients on the wards daily.
- A medical handover had been introduced three times a day on ward 2. One of the clinical directors told us work had been done on improving the handover between the ward and on call teams but this needed time for the practice to become embedded.

Major incident awareness and training

- Senior staff clearly explained their major incident and business continuity plans. The actions described were in line with the trust's major incident plan.
- Staff knew how to access the major incident and continuity plans on the intranet and explained the steps they would take to seek instruction from senior staff.

Are medical care services effective?

Medical care (including older people's care)

Good

We rated the service as good for effective because:

- Care and treatment was mostly planned and delivered in line with evidence-based guidance.
- The service participated in relevant local and national audits. Patient outcomes were monitored.
- Staff assessed and managed patients' pain relief, nutrition and hydration.
- Multidisciplinary teams worked together to understand and meet people's needs.
- Consent to care and treatment was obtained in line with legislation and guidance. Staff demonstrated an understanding of consent, the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLs).

However, we also found:

- Some policies were out of date, or did not meet national recommendations.

Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust intranet.
- The stroke pathway was updated in December 2015 and referenced National Institute of Clinical Excellence (NICE) guidance. Patients could access liaison psychiatry on the neurology ward by a consultant to consultant referral. This is recommended in NICE CG162 stroke rehabilitation.
- Policies and guidelines were based on relevant evidence base and best practice from appropriate professional bodies. However, we found the cellulitis pathway was out of date and due for review in January 2016.
- Early identification of sepsis is known to be important for survival. There was a sepsis management guideline in use at the trust; the one we observed staff using during our inspection was due for review in May 2015.
- Patients that required non-invasive ventilation (NIV) were managed on ward 7. The NIV flowchart for acidotic exacerbations of COPD was written in 2011. It was not in line with British Thoracic Society guidelines, did not contain any references and did not have a review date. This meant that patients in respiratory failure may not have received treatment that was in line with national guidelines.
- Ward 7 used Chronic Obstructive Pulmonary Disease (COPD) bundles that were based on NICE guideline CG101.

Pain relief

- As part of the trust's observation chart and intentional rounding (a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs), staff regularly asked patients about their pain levels and recorded the scores.
- We reviewed patient records and observed staff assessing pain and giving support to patients requiring pain relief.
- Patients told us that their pain was managed effectively and kept under control.

Nutrition and hydration

- Staff screened patients on admission using a nutritional assessment tool. If the assessment triggered a risk or concern staff completed a referral to the dietician.
- The nutritional assessment was complete in 20 of the 22 we reviewed. Both of the fluid balance and food charts we reviewed were complete.
- Patients with special dietary requirements such as those requiring soft diets were catered for.
- Protected meal times were used to allow time for patients to eat sufficiently. Staff told us there were not enough staff to assist with feeding and relatives were encouraged to come and assist patients.
- A red tray was used to identify patients who required assistance or support with nutrition; patients with dementia were served their meals on blue plates. We saw this in use consistently on the wards we visited.
- We saw patients were supported with menu choices and offered snacks. Patients told us they were offered food and water regularly.
- The menu was available in pictorial form for patients with language or cognition challenges.

Patient outcomes

- There were no current CQC mortality outliers in the service. This indicated there had been no more deaths than expected for medical patients.

Medical care (including older people's care)

- The relative risk of readmission rate was lower than the England average for non-elective and elective admissions.
- The trust length of stay was higher than the England average for elective admissions and lower than the England average for non-elective admissions.
- 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 stroke specialist nurse collected data for the Sentinel Stroke National Audit programme (SSNAP). The overall 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; 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 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. 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 endoscopy unit held an audit day quarterly for all staff to attend.
- The haematology and oncology day unit participated in national data collection.
- Service leads participated in regular audit with commissioners mainly looking at readmission rates. An audit on patients that frequently used the service led to the introduction of the frail elderly pathway and other services that had reduced readmission.
- On one day a week the therapists on ward 4 started work earlier to assist people out of bed and with washing and dressing. The evidence had not been formally collated but staff told us results an audit suggested improved staff morale, a reduction in the incidence of call bells ringing and improved patients' eating.

Competent staff

- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. Information submitted by the trust showed at December 2015, 82% of staff in the service had received an up to date appraisal. This was lower than the trust's average appraisal rate of 87%.
- Staff told us they received a trust and a local induction. New members of nursing staff had a supernumerary period with an allocated mentor. They received mandatory training and ward specific training.
- Wards displayed training opportunities for staff. Staff told us the trust supported their training and development, for example, haematology and oncology day unit staff attended acute illness management and introduction to chemotherapy courses. Ward 5 staff were completing on line national stroke competencies.
- The role of the health care support worker was different across the service; some staff had to complete a competency to take patient observations and some staff were informed this was not part of their role.
- Therapy assistants completed competencies, for example, to issue equipment and to carry out a home visit. Some were completing the qualification and credit framework.
- Wards provided placements for student nurses.

- An advanced nurse practitioner in the service was a non-medical prescriber.
- Junior doctors told us they were able to attend weekly teaching.
- Senior staff were confident to manage performance issues in line with the trust policy and support from human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this during our inspection.
- Most wards carried out daily multidisciplinary handovers or weekly multidisciplinary meetings; staff discussed discharge plans as part of these.
- Wards had dedicated physiotherapists and occupational therapists. Access to social workers was dependent upon the geographical location of a patient's home. Staff completed a referral to dieticians and speech and language therapists who visited wards when required. Most wards had a daily visit from a pharmacist.
- All of the records we reviewed had evidence of input from the multidisciplinary team.
- A frail elderly pathway team that consisted of a senior nurse, 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 to try and prevent admission to a ward.

Seven-day services

- There was a 24 hour, seven day a week endoscopy rota for gastrointestinal bleeding that was covered by consultant gastroenterologists and surgeons.
- The frail elderly pathway team was available Monday to Friday between 7:30am and 4:30pm at the time of the inspection due to staffing. They planned to work Monday to Saturday from April 2016.
- The haematology and oncology day unit was open from Monday to Friday 8am to between 5pm and 8pm on different days of the week and operated a telephone triage service. Out of hours calls were managed by another NHS organisation for oncology patients and ward 18 for haematology patients.
- Physiotherapy, imaging services and pharmacy provision was available on an out of hours on-call basis seven days a week. There was no routine therapy in the service at the weekend.

Access to information

- Staff were able to access blood results and x-rays using electronic results services.
- Staff completed an electronic discharge letter that included medications. The GP received an electronic copy and the patient received a printed copy.
- If the frail elderly pathway team were unable to discharge a patient, they provided the ward therapists with their assessment which prevented repetition for the patient and relatives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated an understanding of consent, the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLs).
- Information submitted by the trust showed that overall compliance with consent training in the service was 76% for all staff and 75% for MCA training. This was below the trust target of 80%.
- We observed staff obtained verbal consent from patients before carrying out an intervention.
- All the patients we spoke to told us staff explained their care and treatment to them and sought consent prior to delivering the care.
- Staff told us they would speak to the nurse in charge, a member of the medical team or the trust safeguarding team if they had concerns regarding a patient's capacity.

Are medical care services caring?

Good

We rated the service as good for caring because:

- Feedback from patients and relatives was positive.
- Staff communicated in a kind and compassionate way with patients and maintained their privacy.
- Staff supported patients and encouraged them to regain their independence.
- Patients and relatives told us staff kept them informed of their treatment and progress and involved them in decision making.

Compassionate care

Medical care (including older people's care)

- The NHS Friends and Family Test (FFT) showed a response rate higher than the England average. More than 90% of patients would recommend the service to their family or friends.
- The trust was in the top 20% of trusts for nine of the 34 questions in the cancer patient experience survey 2013/14.
- Prior to the inspection the trust provided results of the real-time inpatient survey for June to November 2015. The survey was split into four sections; cleanliness, accommodation, information and care. Scores on the medical wards ranged from 0% to 100%; the score of 0% was in one month for the questions "did a doctor or nurse talk to you about how the tablets might affect you when you go home?" and "did someone tell you what to look out for when you go home and how to get help?" These scores improved in the following months. Patients scored the majority of the rest of the questions above 80%. For example, for the question "overall, what do you think about the way you have been treated?" the service scored 90% and above.
- Staff treated patients with dignity and respect and maintained their privacy. During all interventions, staff drew curtains around patients and patients were kept covered with sheets and blankets.
- All staff communicated in a kind and compassionate way with patients.
- We observed patients' call bells were placed within reach and staff responded in a timely and respectful manner to patients' requests.
- All the patients we spoke to told us they felt well looked after and the staff were friendly and helpful.

Understanding and involvement of patients and those close to them

- Wards displayed visiting times and information on how to speak with a senior nurse and a doctor.
- Wards used a password system for relatives enquiring about patients to maintain confidentiality whilst enabling staff to provide some information to relatives.
- Patients and relatives told us staff kept them informed of their treatment and progress and that they were involved in the decisions made by all members of the multidisciplinary team.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- We observed staff involving patients in their care in a way they could understand.

Emotional support

- We observed staff interacting with patients in a supportive and reassuring manner, encouraging them to regain their independence in line with their medical progress.
- 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. Wards displayed information about the clinical nurse specialists.
- During our inspection we observed staff on ward 5 recognise that a patient was upset and move the patient's bed into the day room to allow the patient and their spouse to spend some time together away from the busy ward.
- 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.
- A chaplaincy service was available to provide holistic care for patients and support relatives and carers.
- The service had limited access to psychology input.

Are medical care services responsive?

Good

We rated the service as good for responsive because:

- The needs of different people were taken into account when planning and delivering services.
- The strategy focused on patient pathways and flow and improved patient experience.
- The service consistently met the 92% referral to treatment time standard for patients on an incomplete pathway.
- Complaints and concerns were dealt with in an open and timely manner.

Service planning and delivery to meet the needs of local people

- The trust engaged with internal and external stakeholders, patients, governors, members, partners and staff to plan services. Three local clinical commissioning groups commissioned services within the trust.
- The trust 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.
- The right care strategy focused on patient pathways and flow to reduce discharge delays, avoid unnecessary hospital admissions and improve patient experience. The improved partnership working with external partners had reduced the number of patients in hospital with a length of stay of over 30 days.
- The ambulatory care unit was only open between Monday and Friday at the time of our inspection. The management team told us it was planned to move to a seven day service, however, no timescale was available for this.

Access and flow

- There had been no mixed sex accommodation breaches in the last 12 months.
- 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. Each specialty within the service individually achieved the target with the exception of general medicine which was 89.3%.
- The trust provided information that showed 574 patients had been moved after 10pm between June and November 2015.
- Evidence has shown that every ward move increases length of stay (Royal College of Physicians). The trust collected data on the number of times a patient moved beds during an admission. Between December 2014 and November 2015 only 8% of patients moved beds two or more times.
- A medical escalation ward had opened in November 2015; matrons monitored the staffing levels on the ward daily. The trust had recruited winter champions to support the escalation ward and plans.
- In addition to opening the escalation ward, two wards increased their bed capacity, one by seven beds and one by 15 beds.
- Delays in transfer of care and the impact on patient flow were identified on the corporate risk register.
- The service ran a "multi accelerated discharge event" when they worked across the trust and local health and social care partners and focused on reducing the delays in transfers of care for medically stable patients in hospital.
- The safer flow bundle 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.
- A health care support worker led a transient ischaemic attack (TIA) clinic supported by the stroke specialist nurse. The stroke specialist nurse ran a stroke follow up clinic. This improved access to services for patients.

Meeting people's individual needs

- Wards displayed information leaflets for patients and carers, these were available in alternative languages and formats on request.
- The stroke specialist nurse had developed a stroke patient handbook, containing a personal healthcare plan, patient information, discharge information and advice and support following discharge.
- Ward 5 had access to ceiling track hoists and specialist seating. All wards could access equipment for the larger person through a central equipment pool.
- Interpreting services were available for patients whose first language was not English. Staff explained the process of booking an interpreter to us and thought the service responded promptly.
- There was no specialist nurse for dementia, however, a practice development sister for older people was in post and the trust had a dementia action plan. A system was in place when a patient with a known diagnosis of dementia was admitted. The safeguarding team and assistant director for patient safety received an alert and an electronic butterfly icon on the patient administration system informed all staff and triggered the butterfly care plan. We found the butterfly care plan in use on all the wards we visited.

Medical care (including older people's care)

- The wards that had been refurbished had a dementia friendly environment, 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.
- Information submitted by the trust showed that overall compliance with dementia awareness training in the service was 76% for all staff. This was below the trust target of 80%.
- There was no specialist nurse for learning disabilities, however, a matron in the service had a liaison role with patients and their carers and had developed a flowchart for nursing staff on the management of a patient with learning disabilities.
- The patient administration system shared with GPs and community teams identified people with learning disabilities and an email was sent to the lead matron for learning disabilities and the deputy director of nursing when a patient was admitted or had an out-patient appointment in the service.

Learning from complaints and concerns

- Wards displayed information for patients and relatives about their current number of complaints and how to make a complaint or provide feedback.
- Staff were able to describe complaint procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.
- Forty six formal complaints were made in the service between December 2014 and December 2015. This was 60% of all formal complaints made to the trust.
- Ward managers told us the themes of and changes that had been made following complaints. For example, ward 2 had reviewed the ward stock of medications following complaints about the time spent waiting for discharge medications and ward 5 had introduced therapy timetables to address patient expectations and support patients with cognitive impairments following a complaint about the lack of therapy patients received.

Are medical care services well-led?

Requires improvement

We rated the service as requires improvement for well led because:

- 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.
- Morale varied across staff groups with themes being around staff shortages, working additional hours, no capacity to take meal breaks and the type of support received from senior managers.
- Ward managers did not have capacity to take the management time allocated for them to focus on management and administrative issues. Due to staffing levels they were needed to provide clinical care on the ward.
- Some staff raised concerns regarding the style of leadership and management in the service.

However,

- The service had a strategic plan that linked to the trust's strategy.
- Governance structures and processes functioned effectively.

Vision and strategy for this service

- The trust had a vision and a set of values and staff we spoke to knew what these were.
- The directorate had a two year strategic plan that linked to the trust's five year strategic plan. The plan had consideration of quality, safety, risks, solutions and cost improvement.
- The management team were able to explain the strategy for medical care to us. The focus was on further developing the acute care hub and introducing the extensivist model as well as progressing with seven day working, aiming for a seven day ambulatory care unit and daily consultant ward rounds.

Governance, risk management and quality measurement

- The management team explained the governance structure and assurance process within the directorate.
- We reviewed minutes from these meetings and found there was good multidisciplinary attendance. There was evidence of discussion and review of serious incidents, complaints and the risk register and actions from previous meetings. The medical governance meetings fed into the integrated care group management meeting.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring

and the severity of impact. All risks entered on the trust risk management system were assigned a current risk rating. We reviewed the risk register and found risks such as staff suffering work related stress, patients at risk of developing pressure ulcers and a high rate of patient falls had been added to the risk register up to five years earlier. Most risks had been reviewed regularly, however, there was limited evidence of controls in place on both the local and corporate risk registers. For example, the controls in place for nurse staffing on the risk register did not reference the nurse staffing escalation plan that ward managers and senior matrons spoke about during the inspection.

- Ward managers told us their current risks and how they would escalate these. The current risks were included on the directorate risk register.

Leadership of service

- Nursing staff told us they felt supported by their ward manager and senior staff on the ward.
- The service had three matrons and one senior matron. The matrons attended the trustwide nursing and midwifery leadership group and fed back issues from this meeting to the ward managers.
- Ward managers told us the matrons differed in leadership style. The support the ward managers received varied depending on the matron involved.
- Ward managers were supposed to have dedicated management time when they were not expected to be providing clinical care. This would allow them to focus on management and administrative issues. Due to staffing shortages, none of the ward managers we spoke to had capacity to take management time as they were needed to provide clinical care on the ward.
- Junior medical staff told us that the consultant body were approachable and supportive.
- The trust provided an internal leadership programme. We spoke to staff that had completed the programme who spoke positively of their experience.
- The directorate management team felt supported and engaged with the executive team. However, most staff on the wards told us members of the executive team did not complete regular walk rounds in clinical areas; they had seen them in some areas if there had been an incident or issue on a ward.

Culture within the service

- All members of staff we spoke to on the wards were proud to work in the trust and felt part of the team they worked in.
- Morale varied across staff groups with themes being around staff shortages, working additional hours, no capacity to take meal breaks and the type of support received from senior managers.
- Most staff told us they felt supported to report incidents and raise concerns to their immediate line managers.
- Prior to the inspection we received concerns from individuals and a professional body regarding the style of leadership and management in the service. We discussed these concerns with the senior management team who reported that no concerns had been raised internally in the trust and felt confident staff had the opportunity to do so through the freedom to speak up and whistleblowing policy.

Public engagement

- Some wards displayed a "you said, we did" board. Examples of changes that had been made following this feedback were an audit on the discharge process that had been raised as being too slow and the introduction of a radio, television and board games to the ward that patients had said was boring.
- Wards displayed FFT results and cards sent by patients and relatives.
- Ward 5 offered an open evening weekly for the relatives of long stay patients.
- The trust completed a monthly carers audit to understand the hospital experience of people living with dementia.

Staff engagement

- Staff meetings did not take place on most of the wards. Ward managers told us this was mainly due to the staffing issues they faced. Information was shared with staff through a newsletter, staff notice board and urgent issues were communicated verbally by the ward manager or nurse in charge at the safety briefing after handover.
- All staff we spoke to felt that communication within the trust was good.
- Staff spoke enthusiastically about the trust award scheme. Where people and teams had been nominated for or won awards they were on display.

Innovation, improvement and sustainability

Medical care (including older people's care)

- The service was involved in the development of advanced care practitioners to ensure patient care was maintained and ambulatory pathways increased.
- The service had implemented an electronic prescribing and administration system.
- Some wards in the service had implemented electronic rostering.
- Staff on ward 5 were fundraising to buy new technology that would help to prevent recurrent strokes.
- The 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.

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

Information about the service

Airedale General Hospital is part of the Airedale Hospitals NHS Foundation Trust. The surgical services group provides elective and non-elective treatments for breast surgery, general surgery; lower and upper gastrointestinal surgery, trauma and orthopaedics and urology. Visiting specialities included vascular, maxillofacial, ear, nose and throat, oral surgery, ophthalmology and plastics.

The surgical wards usually had 103 inpatient beds over five areas; however, at the time of the inspection surgical wards had 127 beds due to increased occupancy, with an additional 30 day case trollies available.

Between September 2014 and August 2015, there were 18,229 inpatient admissions. Day cases admissions accounted for 58% of all surgical admissions. Emergency admissions accounted for 30% of admissions and 12% were elective admission. General surgery had the biggest percentage of admissions at 37%.

During our inspection, we spoke with 61 members of staff including ward clerks, nurses, doctors, domestics and allied health professionals. We spoke to 20 patients and two relatives. We visited all surgical wards, theatres and day surgical units. We reviewed 32 sets of patient records including medical, nursing and medication charts. We observed care and treatment of patients and reviewed a range of performance information about the Surgical Services Group.

Summary of findings

We rated surgical services at Airedale hospital as requires improvement overall because:

- We had concerns about the escalation process of deteriorating patients; systems used were not always effective. There was inconsistency in the application of systems, processes and standard operating procedures, including the five steps to safer surgery, to keep people safe, particularly with theatres.
- Medicines were not always managed, stored and administered appropriately.
- Communication by medical staff during surgical patient handover's was not effective, and from records we reviewed, we were unable to demonstrate effective review of orthopaedic patients by consultants.
- Care and treatment did not always reference current evidence based guidance, standards or best practice and patients did not always receive adequate and effective pain relief.
- The surgical services management team and senior nursing team had recently had new appointments with positions, which required more time to develop and become fully effective. We had concerns over the substantial and frequent staff shortages and the response of the senior nursing team to staff shortages in the group. Due to staffing levels, ward managers were required to provide clinical care on

Surgery

the ward and did not have capacity to focus on management and administrative issues. We also had concerns over the support matrons offered ward managers and the confidence ward managers had in matrons within the group.

- There were periods of understaffing across a number of clinical areas.

However, we also found that:

- Incidents were reported, investigated and lessons were learned.
- National performance targets were being met, except the referral to treatment times for some surgical specialties. Learning from complaints was not always evident.
- Wards and departments we visited were visually clean and there was evidence of compliance with infection control standards in most areas.
- Surgical services group had a well-documented vision and strategy documents for use in surgical services group, however staff were not always able to articulate the vision and strategy on the wards and departments we visited.
- The inspection team were impressed with the leadership and dedication from the manager and staff working on ward 9. The team working in this area had recently won a number of internal awards.
- Joint community and acute hospital records improved communication between all teams involved in the patient's care.
- Patients on the wards we visited appeared happy and the majority of patients we spoke with were positive about the care they received. We observed positive interaction between patients and staff. Feedback from patients and relatives was positive.
- We saw good evidence of effective multi-disciplinary team working with in the orthopaedic department. Staff working within orthopaedics were knowledgeable about the discharge arrangements

for patients in different commissioning areas. Services were planned in a way to meet the needs of the local population and cancellation of operations prior to and on the day of operation was low.

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Are surgery services safe?

Requires improvement

We rated surgical services at Airedale hospital as requires improvement for safe because:

- We had concerns about the escalation process of deteriorating patients; systems used were not always effective.
- There was inconsistency in the application of systems, processes and standard operating procedures, including the five steps to safer surgery, to keep people safe, particularly within theatres.
- Medicines were not always managed, stored and administered appropriately.
- Communication by medical staff during surgical patient handover's was not effective, and from records we reviewed, we were unable to demonstrate effective review of orthopaedic patients by consultants.
- There were periods of understaffing across a number of clinical areas.

However, we also found that:

- Incidents were reported, investigated and lessons were learned.
- Wards and departments we visited were visually clean and there was evidence of compliance with infection control standards in most areas.
- Joint community and acute hospital records improved communication between all teams involved in the patient's care.

Incidents

- No never events had been declared within the surgical services group in the reporting period February 2015 to January 2016. Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers.
- Serious incidents are incidents that require further investigation and reporting. The surgical services group reported six serious incidents (SI) during the reporting period February 2015 to January 2016. We reviewed two SI reports including a medication incident and an operation undertaken without valid consent. Investigations and actions taken post incident were clear. The investigators had identified areas for future learning and methods of sharing the report were clear. Staff we spoke with were aware of recommendations from serious incidents.
- The surgical services group reported and managed incidents investigations using a national computer system. We reviewed incident data supplied to us by the trust which showed surgical wards and surgical services group reported 472 incidents (rated as harm which was moderate, severe, resulting in death or abuse) in the reporting period February 2015 to January 2016. Reported incidents we reviewed showed one graded as death and one graded as severe harm. Ten were graded as moderate harm, 130 graded as low risk and 330 graded as no harm/ near miss.
- Reported incidents showed the top three categories of incidents reported were patient accidents (128 reports), treatment and procedure (75 reports) and implementation of care and ongoing monitoring/review (53 reports). Staff we spoke with were aware of the top three incidents.
- Nursing and medical staff we spoke with were aware of the reporting system and staff could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. The majority of staff we spoke with said that they received feedback following completion of incident forms.
- Staff told us that learning from incidents was shared internally through communications files, staff newsletters and safety briefs prior to handovers. Staff also told us about a weekly safety brief outlining issues and themes within the trust such as improved education about Parkinson's disease, which included access to the specialist nurse, medication guidance and training. On ward 14, we saw internal memos of Root Cause Analysis (RCA) findings; staff were required to sign these as read.
- Deaths reported in orthopaedic department were discussed at the orthopaedic audit meeting. A slight increase in fractured neck of femur mortality rate had been identified and the trust had commenced a working group to examine the reasons for this.

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Duty of candour

- The ward staff we spoke with were aware of duty of candour requirements and described it as being open and honest when incidents occurred. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Within the theatre suite, staff were aware of the need to be open and honest with patients. They were able to provide examples about being honest and open about example theatre cancellations, mistakes in booking patient scans and patient accidents such as falls.
- Records of duty of candour discussions were documented on the incident records system and within patient medical notes.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harm and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots) and catheter and urinary tract infections (CAUTI's).
- In the reporting period, September 2014 and September 2015 there had been 17 pressure ulcers, 13 falls with harm and 12 CAUTI's.
- Venous thrombolysis (blood clot) assessments were carried out in the trust and surgical services group audit data from November 2015 that we reviewed showed 97.7%, of patients received the appropriate assessment of risk.

Cleanliness, infection control and hygiene

- Wards and departments we visited were visually clean; however, we saw some areas that required further cleaning.
- We observed staff washing their hands, using hand gel between patients and staff complying with 'bare below the elbows' policies.
- Hand hygiene audit data we reviewed showed 98% compliance against a trust target of 95% in the reporting period November 2015. During the inspection, we saw hand hygiene compliance data displayed on the wards and department we visited. We noted good availability of alcohol gel and soap dispensers we reviewed were all in working order.
- During the inspection, we observed good compliance with IPC policies for example rooms were available for the isolation of patients, and patients requiring isolation were isolated. However, within theatre suite all four sharps bins we reviewed did not include signatures or date of assembly.
- Infection prevention and control (IPC) information was visible on all wards we visited. This included information the current hand hygiene compliance rate, the number of days since last Clostridium difficile (C.diff) infection and Methicillin Resistant Staphylococcus Aureus (MRSA) isolate.
- The trust had reported two cases of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) in the reporting period April 2015 to November 2015. In the same reporting period, of the nine reported cases of hospital acquired clostridium difficile (C.diff), three cases were defined as avoidable. This was above the agreed threshold for hospital acquired MRSA and above the agreed threshold for hospital acquired C.diff. Within the surgical service group, there had been an increase in reported cases of C.diff cases attributed to general surgery (three cases). Staff had been reminded to consider C.diff earlier in the patients' admission pathway.
- The trust screened surgical patients for MRSA in accordance with national guidance.
- The trust participated in national surgical site infection surveillance for patients undergoing orthopaedic surgery following a fractured neck of femur. Data we reviewed showed that during the reporting period April 2015 to June 2015, the current surgical site infection rate was 0% which was lower than the 'all hospitals' England average of 1.5%.
- Orthopaedic staff we spoke with highlighted that there was insufficient capacity within laminar (specialised ventilation) theatres. The senior management team were aware of this issue and told us they had plans to undertake a theatre refurbishment project to increase the availability of laminar flow theatres. However, no detailed plans were available.

- The elective orthopaedic ward was ring fenced for elective orthopaedic patients only, to prevent infection as per best practice guidance.
- We did not see labels were used to identify the cleanliness of commodes or other equipment used on ward 13. Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use.
- The infection prevention and control (IPC) team delivered training both face to face and via e-learning. IPC training compliance rates for the surgical area was 52% with a trust target of 80%.
- There was a carpeted area on ward 19. During the inspection, we saw this ward was used for elective orthopaedics and the carpet was visibly stained in several areas. Carpet is not a recommended floor covering for in-patient clinical areas. No removal plan was available and it had not been identified as a risk on the risk register.
- Within the theatre environment, there was an inconsistent approach to decontamination of laryngoscope handles. No clear policy was available.

Environment and equipment

- The trust had recently painted the some of the ward areas in dementia friendly colours. Day rooms had been decorated in bright colours and were tidy, welcoming areas.
- Within the theatre suite, storage was listed as a risk. This had been on the register since 2013. Actions recently taken indicated that a full review of storage within theatres had been undertaken. During the inspection we saw that areas within theatre appeared cluttered, for example recovery rooms and corridors.
- We reviewed safety checks of five anaesthetic machines; records reviewed did not provide assurance that daily safety checks had been undertaken. All anaesthetic records we reviewed showed several gaps in the recording of safety checks. Staff we spoke with acknowledged the need for daily checks. The Association of Anaesthetists of Great Britain and Ireland (2012) recommend a pre-use check of the anaesthetic equipment. We informed the theatre management team of these concerns at the time of inspection.
- On most areas visited resuscitation equipment was managed and recorded as checked appropriately. On ward 14, we found that resuscitation equipment we reviewed were poorly managed and recorded, records were not filled in chronological order and equipment-checking records were stored with other documents in a file making it hard to understand when the trolley was last checked. We also found gaps in recording that the equipment had been checked. We highlighted this directly with the Matron at the time of the inspection.
- Single use equipment that we checked was stored appropriately and within expiry date.
- Electrical equipment that we checked was found to be in date for servicing and electrical safety checks.
- There were adequate stocks of equipment and we saw evidence of good stock rotation.

Medicines

- Electronic prescribing was used on wards. A recent issue had been highlighted on surgical wards with problems prescribing discharge medications and patients were being prescribed old medications. Actions taken included additional pharmacy staff being placed on the affected area.
- Medicines were stored securely and we saw records to show emergency medicines were regularly checked as per trust policy to make sure they were safe to use.
- Controlled drugs (CDs) were stored securely and access was restricted to authorised staff. Accurate records of CDs were not always maintained; we reviewed records on three surgical wards and noted controlled drug records had been amended and not signed as per good practice guidance. For example, corrections on stock levels weren't 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. Staff had not written the date of opening on the bottle so had not noted that the medicine had expired. This was removed whilst we were on the ward. We saw records that showed this had also happened on the ward in December 2015. A patient had received eight

doses of expired liquid CD and this had been identified by a pharmacist. The member of staff we spoke with was not aware of any action taken after the first incident to ensure the same thing did not happen again.

- Medicines requiring refrigeration were not always stored and monitored according to the trust policy.
- Maximum and minimum fridge temperatures were not always recorded daily. We observed that wards were not always taking action when fridge temperatures were outside the recommended range. For example, records on ward nine showed seven days in a sixteen day period when the maximum fridge temperature had been recorded as 12.3 Celsius and no record had been made of any action taken.
- We saw patients being offered and administered medications. Staff checked Identification bracelets prior to administration and help was provided to take medication if required.
- We saw oxygen and saline flushes were prescribed appropriately when needed.
- Medicines were not always transferred with a patient when they moved ward. For example, we saw insulin in the fridge for one patient that had moved to another ward.
- The discharge checklist staff showed us did not include any reference to checking if a patient brought their own medicines to hospital with them. We saw patients own controlled drugs were not always returned to the patient when they were discharged.

Records

- A mixture of electronic and paper records were available for each patient that attended the wards. Patient records were stored in noted trolleys; all records we reviewed were stored securely.
- We reviewed 32 sets of medical and nursing care records whilst on site and on the majority of occasions, these were accurately completed.
- Nursing records, we reviewed were legible, the majority were completed accurately. Documentation occurred at the time of the review or administration of medication as per compliance with trust policy and professional standards.
- The wards used risk assessments for falls, pressure damage prevention and records we reviewed showed that on the majority of occasions these were completed accurately. We noted that a person identified as having a risk of absconding (leaving the ward suddenly without telling anyone) was documented to need review every 24 hours. There was no record of review in the person's notes. Staff told us this was because the risk had not been handed over from another ward.
- Completion of venous thromboembolism (VTE) assessment was noted to be 97.7% for November 2016, better than the trust compliance rate of 95%.
- During the inspection, we reviewed key performance indicators for record keeping audits, most areas showed good compliance with the indicator. However, on ward 9 and ward 19 poor compliance was noted for prescription, nutritional and fluid balance chart completion and other risk assessments completion during the reporting period October 2015 to November 2015. When we discussed with the areas, they could identify the reasons for low compliance for example staffing levels.
- The trust used a joint community and acute electronic records system, staff told us that the benefits to this system were that up to medication, discharge letters and other key information, was available to acute and community staff at all times.

Safeguarding

- The surgical services group had systems in place for the identification and management of adults and children at risk of abuse. During the inspection, we reviewed records and noted compliance with the trust safeguarding policies and referrals being made to safeguarding teams.
- Staff we spoke with were able to describe their roles in relation to the need to report and take action as required when safeguarding issues were identified. An electronic referral system was available and staff we spoke with were aware of the process for escalation.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by yearly safeguarding refresher training. We reviewed safeguarding training compliance rates for the surgical area and found 81% of surgery nursing staff had

up to date training in Adult Safeguarding, and 75% had up to date training in Safeguarding Children. For medical staff, 96% had up to date training in Adult Safeguarding and 89% had up to date Safeguarding Children. The trust's internal target for this training was 80%.

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or via e learning.
- The trust target for mandatory training completion was 80% compliance. Training data (January 2016) showed 61% of surgery nursing staff had up to date training in mandatory training modules overall. For medical staff, the trust met the target with 81% completing mandatory training. Within the theatre, suite 62% of staff had received mandatory training. Managers had been reminded to encourage staff to attend training; we did not see any other plans to meet the target level.
- The majority of the staff we spoke with said that they had outstanding mandatory training requirements and most staff told us that this was due to staffing issues and been unable to access training.
- New staff received a corporate and an area specific induction, which included some aspects of their mandatory training.

Assessing and responding to patient risk

- The trust used the national early warning score (NEWS) tool; surgical areas used a paper based system to record the early warning scores. Nursing staff highlighted deteriorating patients to medical staff by an internal bleep system. Nursing staff we spoke with were aware of the procedure and appeared knowledgeable about when to take action when patients deteriorated. However, records we reviewed and staff we spoke with showed the escalation of deteriorating patients did not always follow the documented process within the hospital. Staff we spoke with said that they would call the on-call medical staff or acute care team, and they would not escalate as per the pathway, even if the score indicated this course of action. However, staff did say that if they were not able to get a reply they would escalate to a consultant. Records we reviewed showed that out of ten NEWS scores recorded, 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.
- 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 key performance indicator audits carried out on retrospective notes 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. We reviewed three sets of post-operative surgical notes containing WHO checklists and we observed one completed accurately, one sign out not completed and no records were available for the third. A bespoke WHO checklist was available for patient having eye surgery. Staff we spoke within theatres stated that the checklist required further embedding.
- During the inspection, we witnessed a case where a member of staff had signed the instrument checks as complete on the instrument check sheet prior to the surgery being commenced. We highlighted this issue at the time with senior staff and immediate action was taken. We also discussed this with the senior management team who provided further information about subsequent actions taken. We also witnessed another occasion where instrument check forms were not accurately completed; we reviewed four sets of post-operative notes and found no evidence of a swab instrument checklist being completed.
- When patients were admitted, they were seen by either a first or second year junior doctor and then reviewed by a more senior grade of staff. Medical notes we reviewed and patients we spoke with showed us that if patients were admitted in the middle of night and assessed as being stable, review of the admission by a more senior grade did not always occur until the ward round the next morning.

- We had concerns over the consultant review of trauma and orthopaedics patients. Records we reviewed showed that a first year junior doctor often undertook ward rounds alone and from records we reviewed, no reference to senior medical staff being available, or discussion with seniors was apparent. Senior medical staff confirmed that they undertook regular ward rounds, however; from discussions with medical and nursing staff, we saw that it was not clear as to the arranged day that consultant ward rounds or to whether it formally took place. Staff we spoke with did confirm that the consultant saw all patients on their first day following surgery. We discussed this with the senior management team and they informed us that ward rounds were not in the job plans of consultants, however they did state that ward rounds were undertaken 2-3 times per week; we were unable to confirm during the inspection.
- We had concerns over the effectiveness of surgical handover; medical staff had highlighted to the general medical council inconsistent surgical handovers previously. During our inspection, we tried to attend a surgical handover; however, one did not occur at the arranged time. We discussed this with the clinical director and he confirmed that this had been highlighted within the trust and an audit project had been undertaken. Results we reviewed for November 2015 showed that a consultant was present on 42% of occasions (target 100%) and the handover list was available complete and up to date on 35% of occasions (target 100%). Recommendations were made that it was mandatory for consultant to be present, ward manager from ward 14 surgical admissions area to be present and all team to be responsible for updating the handover list. A plan to re-audit in 3 months was indicated, this had not happened at the time of the inspection.
- One area, ward 18, elective orthopaedics moved on an annual basis to ward 19 with a smaller number of beds to accommodate winter pressures. This area had all single rooms. During the inspection staffing on this area especially overnight was a concern. The ward had recently highlighted that they had recognised an increasing number of falls had occurred during the recent move when comparing data from April to October 2015 (27 weeks pre move). The ward had reported eight falls (0.3 per week). In the 16 weeks since the move, the ward had reported six falls (0.4 per week). During the course of the inspection, the ward highlighted this to the Matron in charge of the unit.
- Access to advice and treatment post discharge following day surgery was via the patients GP or via the emergency department.

Nursing staffing

- At the time of the inspection, surgical wards and departments had 185.3 WTE registered and unqualified nursing posts (including critical care). We reviewed vacancy rates and this showed 20.8 WTE; most areas we visited had staff vacancies.
- The trust used the safer nursing care tool to asses nursing staff requirements per ward, per shift. The last acuity assessment undertaken at the trust was in October 2015 and included a review of the inpatient activity on surgical wards. Following this review the trust board had agreed to increase the nursing establishment on wards 14 and 9. All surgical wards displayed planned and actual nurse staffing levels for each shift.
- The trust-defined qualified nurse to patient ratio was 1:8 in the day and 1: 15 at night on surgical wards and on the surgical assessment unit, 1:6 day and night. Ward 19 was all single rooms and the aspirational ratio was 2:11 patients. During the inspection, we saw these ratios being achieved.
- Prior to the inspection, in January 2016 surgical wards achieved 90.6% to 98.5% fill rates for qualified nurses (day shifts) and 80.7% to 100% (night shifts). Data we reviewed December to March 2015 showed that out of 155 shifts, the percentage staffing levels fell below 90% (day shift) on 55 occasions (range 5 to 16 shifts per area) and 21 night shifts out of 155 occasions (range five to16 shifts).
- We reviewed duty rosters for the previous three months out of 288 registered nurse shifts reviewed we saw that 85 shifts were staffed at below the established levels. Registered nurse staffing levels had been below established levels on all surgical wards over the previous three months.
- On most wards we visited staff worked overtime or on the nurse bank out of the 288 shifts we reviewed 54 shifts were covered by staff working overtime or on the

bank. At the time of the inspection, many of the staff we spoke with worked additional overtime hours; some staff we spoke with told us that overtime was an expectation.

- The surgical services group used bank and agency staff to improve staffing levels. We reviewed use of bank and agency staff during the reporting period of April 2015 to January 2016 and noted 6.6% agency usage. Usage ranged from 10.5% April 2015 to 2.3% January 2016. Staff we spoke with provided examples about agency bookings made late to the agency, for example, less than 48 hours prior to the shift being required so the shift was not able to be filled; every ward we visited had unfilled agency requests. Overall, from records we reviewed a decreasing trend of agency usage was noted. Staff we spoke with said that local induction was provided to new agency staff.
- Staff working in SAU told us that on occasions when unable to identify specific staff for SAU, staff working on ward 14, looked after SAU patients. This occurred most frequently overnight.
- At the time of the inspection, ward 13 (female surgery) was highlighted on the risk register as an area with a number of registered nurse vacancies. No other areas were on the risk register despite a number of areas having below established staffing levels in the months prior to inspection.
- One area we visited (ward 19) staff had been moved to work on other areas on a regular basis. This occurred mainly overnight; on one of these occasions this decision had left one healthcare assistant on their own looking after five patients with no qualified nurses on duty. A door to an adjoining ward was left open, however this area was not fully staffed either and staff told us was not able to provide any support.
- Patients we spoke with on ward 19 told us that staff were very busy and they had to wait to be mobilised, assisted to the toilet or administered pain relief. One patient we spoke with said that in their opinion, staffing on the ward at night was unsafe and dangerous.
- The surgical group was actively recruiting to vacant posts; both local and international recruitment events had been undertaken.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. During the announced part of our inspection, we observed a formal multi-disciplinary team handover and a theatre post-operative handover and heard clear discussion about the patient's clinical conditions, mobility and staff used clear documentation to support the handover. During the unannounced part of our inspection we witnessed that a patient in a side room was not handed over effectively, and both bank staff on the ward were unaware the patient was in the room. The inspection team reported this incident at the time of the inspection.

Surgical staffing

- We examined the medical staffing rota and talked with consultants, middle grade and junior doctors. Medical staff were available 24 hours a day. Junior doctors were available on site 24 hours a day. Middle grade and consultants were available on-site approximately 12 hours a day and on-call for the 24hr period.
- Medical skill mix was similar to the England average for consultants and junior doctors. The consultant level was 39% (England average 41%); middle career level was 26%, higher than the England average at 11%, registrar group was 19% (England average 37%) and junior doctors were 16% (England average 12 %).
- At the time of the inspection, surgical wards and department had 16.8 WTE surgical consultants. We reviewed vacancy rates and this showed 5.5 WTE surgical consultants on surgical wards and no junior doctor vacancies.
- The surgical services group used locum medical staff to improve staffing levels; we reviewed use of locum medical staff during the reporting period of April 2015 to January 2016 and noted 15% agency usage. Usage ranged from 9.5 to 21.3%.
- First and second year junior doctors grades (FY1 and FY2) provided on call cover for new admissions, ward routine work and clinic admissions. Second year junior doctors provided support and advice to first year doctors and covered all admissions in the emergency department, orthopaedics and theatres. Specialised junior doctor grades and consultants were available to review and operate on patients as required.

- Most nursing and medical staff we spoke with talked to us about the gaps in the junior doctor rota both first and second year levels; some gaps had been covered with higher grade junior doctors other gaps had been absorbed into the system, with no additional cover available. Some nursing staff we spoke with gave examples of work that remained outstanding and medical staff were unable to complete overnight due to the admissions workload.
- Junior medical staff (years one and two) we spoke with said they had received time for training and education within general surgical roles, however had limited opportunities within trauma and orthopaedic rotations.

Major incident awareness and training

- The trust had a major incident and business continuity plan. This was available to staff on the trust intranet.
- Staff we spoke had an awareness and understanding of their roles in major incidents.
- Some staff had recently taken part in a regional table top exercise.

Are surgery services effective?

Good

We rated surgical services at Airedale hospital as good overall because:

- National audits showed patient outcomes were mostly the same or better than the England average.
- We saw good evidence of effective multi-disciplinary team working with in the orthopaedic department.
- Staff working within orthopaedics, were knowledgeable about the discharge arrangements for patients in different commissioning areas.

However, we also found:

- We saw evidence that patients did not always receive timely pain relief.
- Surgical guidance did not always follow current evidence based guidance, standards and best practice.

Evidence-based care and treatment

- Surgical guidelines did not always follow national guidance from the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetics, and from the Royal College of Surgeons. For example, a limited number of policies were available which showed NICE compliance.
- Policies were stored on the intranet. Staff we spoke with were aware of how to access policies. There were a limited number of surgical policies of the intranet. From a set of surgical group meeting minutes, we noted that the trust had set up a spreadsheet for recording compliance with NICE, the author had commented that there was "not many policies for surgery". Policies were not always available for procedures carried out, for example, cleaning of reusable laryngoscope handles.
- We saw staff were not always using the most up to date version of trust policies. For example, on ward 13 the sepsis policy displayed expired in 2008. Staff showed us another printed version that was due for review in November 2014; the version on the intranet expired in May 2015. There is a risk that staff may not always be referring to the most up to date guidelines available.
- There was a range of standardised, documented pathways and agreed care plans across surgery. Examples of these included enhanced recovery for orthopaedic patients, fractured neck of femur, hip, and knee replacement pathways. We saw the pathway for admission into the surgical admission unit displayed, however; this was a draft pathways and did not include authors titles, dates or refer to appropriate guidance.
- We saw evidence of discussions in accordance with the National Confidential Enquiry into Patient Outcome and death (NCEPOD) guidelines.
- The trust participated in national audits such as bowel cancer, lung cancer and emergency laparotomy audits. The surgical care group had a clinical audit programme, which included audits being undertaken on antibiotic administration on septic shock, management of surgical abscesses and management of clinical conditions.
- The surgical services group had a local clinical audit programme; this included participation in national audits and participation in local audits and projects.

Pain relief

- We saw patients on wards 9 and 14, being offered pain relief; however the majority of patients we spoke with (six out of 10 patients) said that pain relief was not always offered or staff did not always provided in a timely way. Patients and staff working on ward 19 expressed concerns to us that patients often waited too

long to be administered pain relief due to staffing shortages and due to some pain relief requiring two registered nurses to sign records and wards having to share registered nurses.
- The inpatient survey (2016) looked at people who received care at the hospital in July 2015. This found that patients scored about the same as other trusts for the question whether hospital staff did all they could to help control their pain.
- Staff used pain scoring tool to assess patient's pain levels staff recorded the assessment on the patient records.
- Staff told us they used a pain scoring tool, which was available on the trust's intranet, for patients with dementia. We saw scores had been documented on the observations chart.

Nutrition and hydration

- We saw staff offering patients food and drinks and we saw staff assisting with meals. Staff identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes, by discussion with the patient and relatives, nutrition assessments and my monitoring eating habits.
- Staff recorded nutritional needs in patient's notes. The surgical group used the national malnutrition universal screening tool (MUST) nutritional risk assessment documentation, and documentation we reviewed showed good levels of completion.
- Patients had access to fresh water where appropriate and fluid balance charts we reviewed were accurately completed.
- During out of hour periods, a limited number of food choices were available to patients such as salads, sandwiches and biscuits.
- Staff were able to provide biscuits as snacks; no further snack menu was available.
- During the inspection, national nutrition week occurred and dietitians and staff on the ward took part in the week by offering patients extra snacks and providing information about nutrition and offering newsletters about improving eating habits.

Patient outcomes

- The trust standardised relative risk readmission rates for both elective and non-elective surgery was similar to the national average. Trauma and orthopaedics was higher in both elective (133-trust rate versus 100 England average rate) and non-elective patients (112-trust rate versus 100 England average rate).
- The national bowel cancer audit (2014) 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% versus the England average of 54.8%. %.
- We found that the National Emergency Laparotomy Organisational Audit 2015 showed the trust scored green in three out of 11 outcome measures; seven scored amber and one scored red as less than 50% of patients had an assessment by MCOP specialist where the patient was aged over 70 years.
- The lung cancer audit (2014) 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 a CT scan before bronchoscopy. The third indicator of the lung cancer audit indicators showed similar results to the England average, as the trust had 13.7% of patients who 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. Surgery on the day of or after day of admission was higher 75% than the England average 72.1%. Performance was worse for patients admitted to an orthopaedic ward within 4 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).
- Older patients admitted to hospital with fractured neck of femurs had access to orthogeriatricians; these speciality doctors reviewed older patients for reasons why they fell, bone health and prevention strategies for further falls. Multidisciplinary team meetings were held weekly to discuss patients. The trust had recognised that mortality in this group of patients was slightly higher than the regional mortality levels and had convened a task and finish group to understand the reasons for this.

- 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 surgical services group held surgical speciality audit meetings. Minutes we reviewed from the orthopaedic meeting showed good attendance and discussions about orthopaedic deaths, intensive therapy unit usage and complications requiring further admission.
- Enhanced recovery pathways were in place for bowel and orthopaedic surgery.
- Nursing staff provided patient comfort rounds and undertook inspections of patient's skin conditions and assessments of the risks to patients developing pressure ulcers this was documented in the patient notes.
- The department monitored their performance against a range of clinical indicators via a performance dashboard. This data included performance on clinical outcomes and national targets. Performance data was discussed at divisional group meetings.

Competent staff

- Appraisal records we reviewed showed that within the surgical services group 83% had an up to date appraisal. For medical staff, 74% had an appraisal and 82% for nursing staff; this was lower than the overall trust rate of 87%. Staff we spoke with said they had all had an up to date appraisal.
- Staff we spoke with said that new nursing staff to the ward or department received a local induction.
- Newly appointed healthcare assistants had a competence booklet to complete this was based on national standards.
- Some senior healthcare assistants had received additional training through a local university to allow them to undertake additional roles and skills such as patient admissions, taking blood and catheterising male patients.
- No specific physiotherapy competencies were available on the orthopaedic department to enable staff to safely move patients and assist with exercises.
- We saw specific competencies developed for theatres in relation to skills required to work in the different specialities.

Multidisciplinary working

- There were established multi-disciplinary team (MDT) meetings for patients on cancer and orthopaedic neck of femur pathways. These MDT's included specialist nurses, surgeons, anaesthetists and radiologists. An ortho-geriatrician provided ward cover on the trauma and orthopaedic wards.
- Clinical nurse specialists came to the wards to provide clinical expertise and review patients.
- Due to the geographical location of the hospital, staff working in the hospital frequently discharged patients to different commissioning areas. Staff we spoke with told us about discharge issues in relation to equipment requirements, home care assessments and nursing input. Staff we spoke with were very knowledgeable about these issues, and solutions to the issues.

Seven-day services

- On-site medical cover was available 24 hours a day; junior doctor cover was available on site 24 hours a day with senior medical cover from middle grade doctors and consultants available on an on-call basis.
- When providing on-call duties a single second year junior doctors covered all surgical specialities such as General surgery, Orthopaedics, Urology and Paediatric surgery. Junior doctors we spoke with told us that the on-call period could be busy.
- Out of hours, there was a hospital at night service running from 20.30 to 08.30 Monday to Friday and 24hours at weekends and bank holidays. This service provided access to the Acute Care Team (ACT) including senior nursing staff, medical staff.
- Access to radiology services were provided 24 hours, seven days a week, to support clinical decision making.
- Access to occupational therapy and physiotherapy services were available Monday to Friday with an on-call physiotherapy service provided at a weekend.
- Pharmacy staff were available Monday to Friday, in addition, an on- call service was available overnight and at a weekend.

Access to information

- Staff recorded information about patients in paper format and on joint community and acute computer systems. During the inspection, we reviewed the system and noted that icons were available for discharge planning, pharmacy reviews, falls risk and diabetes.
- Computers were available on the wards and departments these were used by substantive staff. Agency staff did not have access to the computer system, substantive staff had to record data on the computer system on their behalf.
- Handover reports were computer generated, following information updates from staff.
- Discharge summaries were prepared for the GP; staff working on surgical wards used the same computer system as GP's. Records we reviewed showed comprehensive, relevant information being shared and these were completed in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed clinical records and observed that patients consented to surgery was in line with trust policy and department of health guidance.
- Nursing and medical staff obtained consent via both verbal and non-verbal routes. The staff we spoke with understood the principles of consent and provided examples of when they obtained consent. They were aware of how to gain both written and verbal consent from patients and their representatives. We observed staff obtaining consent before undertaking clinical procedures.
- We reviewed a recent serious incident, which had been investigated in relation to inappropriate consent. The investigation found that staff had a lack of awareness in best interest decisions and checking patients consent prior to surgery was not effective. The trust had developed bespoke surgical Mental Capacity Act (MCA) training, annual audits on consent form usage to be undertaken and had reviewed locum medical staff consent competencies.
- Staff we spoke with were knowledgeable about the MCA and Deprivation of Liberty Safeguards (DoLS). During the inspection, we reviewed nine patients with a DoLS on an orthopaedic ward. We found they were all appropriate, and the process had been followed accurately.
- Where patients lacked capacity to make their own decisions, staff were aware of who was able to legally make decisions on behalf of the patient.
- Training records for the surgical services group showed 79.4% of staff had undertaken mental capacity act mandatory training against a trust target of 80%.
- The surgical group completed an audit of consent; auditors used retrospective case note review and patient questionnaire. Conclusions from the audit in October 2015 showed that on most of the standards measured, scores stayed the same or improvements were noted since the 2014 audit. Eleven of the 15 standards assessed scored 100% scores. Low scores (21%) were noted to other possible treatments discussed standard; however, this was a 3% improvement on 2014 data.

Are surgery services caring?

Good

We rated surgical services at Airedale hospital as good overall because:

- Patients on the wards we visited appeared happy and the majority of patients we spoke with were positive about the care they received.
- We observed positive interaction between patients and staff.
- Feedback from patients and relatives was positive.

Compassionate care

- We spoke with 20 patients and two relatives across the surgical wards and department. During the inspection, we observed positive interactions between patients and staff. We observed staff being supportive, enabling and encouraging of patients. Patients on the wards we visited appeared happy.
- The majority of patients we spoke with told us that the care they had received in the surgical services group at Airedale Hospital was positive; they told us that staff introduced themselves, were approachable and were helpful. Patients we spoke with also said that they were satisfied with the care they received and said that care they had received was better than their previous experiences.

Surgery

- The NHS Friends and Family test (FFT) is a satisfaction survey that measures' satisfaction with the healthcare the patient has received 2,380 responses in the reporting period August 2014 and July 2015 the Friends and Family response rate was 35.5% the same as the England average response rate. Average responses fluctuated from ward to ward between 23% for ward 13 and 72% ward 19. Recommendation scores in each ward ranged from 94.7% ward 13 and 99.5% ward 19. Friends and family information was shared with the public on all wards we visited.
- The trust was in the top 20% of trusts for nine of the 34 questions in the cancer patient experience survey 2013/14.The trust scored green for the questions did staff give complete explanation of the purpose of the tests and explanation of the test results and involving patients in the decisions about their care and treatment.
- We observed staff treating patients with dignity and we observed staff closing curtains/doors whilst delivering personal care.
- We observed patients' call bells were placed within reach and staff responded in a timely and respectful manner to patients' requests.
- During the inspection, we saw staff holding an afternoon tea party for patients. Staff had invited patients and relatives to the ward dayroom on ward 9 and staff offered tea, cakes and snacks. Music was playing in this room and all staff, patients and visitors appeared happy, comfortable and content.

Understanding and involvement of patients and those close to them

- The majority of patients we spoke with said that they felt fully involved in their care decisions. This included discussion of the risk and benefits of treatment.
- Patients said they felt that staff listened to the, they knew who to approach if they had issues regarding their care, and they felt they were able to ask questions.
- Patients we spoke with were all aware of their discharge arrangements and actions required prior to discharge.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.

Emotional support

- We observed staff interacting with patients in a supportive and reassuring manner; we saw staff encouraging patients to regain their independence post-operatively.
- A multi- faith chaplaincy service was available within the trust and during the inspection.
- Clinical nurse specialists were available within surgery and provided support to patients following breaking bad news and for continuing care and treatment. Examples were stoma care and colorectal nurse specialists.
- Quiet areas were available on every ward we visited to enable patients and relatives to be spoken with privately. Some areas had access to fold out beds in quiet areas to accommodate overnight stays.

Are surgery services responsive?

Good

We rated surgical services at Airedale hospital as good overall because:

- Services were planned in a way to meet the needs of the local population
- Performance was better or similar to the England average in all measures for cancer referrals.
- Length of stay data showed that the trust performed better than the England average for all types of elective admissions and non-elective admissions.
- Cancellation of operations prior to and on the day of operation was low. Effective systems were in place to meet people's individual needs including those living with dementia or a learning disability.

However, we also found:

- Some specialties had not met the 18-week referral to treatment standard for incomplete pathways.
- Learning from complaints was not always evident.

Service planning and delivery to meet the needs of local people

- Surgical services provided on an elective inpatient and day case basis for Trauma and Orthopaedics, General Surgery, lower and upper GI surgery, Urology and Breast surgery. Visiting specialities included Vascular,

Maxillofacial, Ear, Nose and Throat, Oral surgery, Ophthalmology and Plastics. These services provided day case and outpatient services and were provided through a service level agreement with a neighbouring NHS trust.

- The surgery care group had seen a 10% rise in elective activity in the reporting period April to November 2015.
- Surgical services had outlined partnerships, alliances and areas for de-investment within the annual plan 2015/2016, for example improved partnerships and alliances with neighbouring trust.
- An evening theatre list was available for urology patients.
- Joint replacement education occurred in the trust; however, during the inspection we saw that an effective process was not in place to book patients to attend joint school.
- Quiet areas were available on every ward we visited to enable patients and relatives to be spoken with privately. Some areas had access to fold out beds in quiet areas to accommodate overnight stays.

Access and flow

- NHS England published operational standards for the expected level of referral to treatment standard (RTT) for patients, all providers are required to deliver the 18 week standards for each speciality, each month. These are set at (92%) incomplete pathways at and cancer waiting times 14 days (93%), 31 days (94% surgery) and 62 day wait (85%).
- The trust performance of meeting referral to treatment standard (RTT) for all patients in all specialities RTT data for February 2016, showed 92.4% similar to the 92% national standard.
- All surgical specialities other than urology, ophthalmology and ear, nose and throat were performing lower than the RTT standard with general surgery at 86.4%, oral surgery 91.3%, trauma and orthopaedics 83.2% The senior management team were aware of the reasons for this performance, for example not enough orthopaedic theatre capacity .
- We reviewed the cancer standards and noted that performance was better or similar to the England average in all performance measures. Data we reviewed from February 2016 showed that the 14- day standard was met at 99.2%. This was better than the England average (93%). The surgical services group had met the 31- day standard consistently since April 2013; Year to date (YTD) data showed 100% which was better than England average (94%). The 62- day standard was 85.7% for current performance and was the same as the England average (85%).
- Surgery was undertaken in six operating theatres; a separate day surgery unit was available and was predominantly used for ophthalmology and community dental cases. Data we reviewed showed theatre usage was 87% to 92% overall between September 2015 to November 2015. Elective theatre lists were available five days a week and emergency theatre lists were available seven days a week. Access to emergency theatres was available 24 hours per day, as per NCEPOD guidance. However, orthopaedic trauma and general surgery shared theatre access overnight and at weekends. The group had undertaken an assessment of one theatre as a baseline for “perfect week” to get a baseline of the reasons theatres overrun, did not start on time or had downtime. Conclusions from the assessment were to review medical staff job plans, clinical teams and staffing and separate elective and acute patients.
- In the trust, the overall the percentage of operations cancelled was consistently below the England average at less than 1% than the England average (0.8 %). The trust cancelled 92 patients’ operations in the reporting period April 2015 to August 2015 for non-clinical reasons including cancellation by the patient. On the day cancellations April 2015 to March 2016 were 189 patients; reasons for on the day cancellations were list overruns and equipment, bed and staff shortages. When cancelled patients must be booked for surgery within the 28 days from the cancelation as per the national standard. Between April 2013 and June 2015 only one patient was not rebooked in the appropriate time; this occurred in Q3 of 2014/15.
- The current length of stay data showed that the trust performed better (2.9 days) than the England average of 3.3 days for all types of elective admissions and non-elective admissions. Only elective urology had a higher length of stay 2.5 days than the national average 2.1 days.
- Pre- assessment services including blood tests and screening was booked to take place as near as possible

to the time of listing to prepare the patient adequately for operation. Pre-operative assessment was undertaken in a dedicated area and a lead nurse and named anaesthetic lead was available.

- The surgical day unit admitted patients direct to the unit before theatre to aid flow within the hospital and to decrease cancellations; patients requiring an overnight stay were allocated a bed from the unit or via recovery unit post-operatively. The day case rate was 58% of surgical activity.
- The senior management team and consultants working in theatres told us about issues with flow within theatre recovery on a Tuesday evening, due to start times, number of operations performed and the number of theatres working overcrowding of the department was occurring. Staff provided examples to us of patients requiring assistance to eat whilst in recovery as they had waited a long-time for a bed to be available. Staff provided examples of when theatre lists had to cease due to overcrowding within the recovery area.
- We had concerns about the surgical pathways for surgical admissions. From records we reviewed, patients appeared to be admitted to the surgical admissions area from the emergency department overnight and not be reviewed by senior staff. We reviewed nine patients admitted overnight and four patients were discharged early the following morning when senior medical staff reviewed the patient. We discussed this with the senior management team and were told that due to the geography of the area they were reluctant to discharge patients late at night.
- Most of the surgical wards we visited had medical patients located on them (medical outliers). Staff we spoke with told us that they had developed a system linking their ward to a medical ward to ensure outliers were regularly reviewed.
- Over the winter period, the trust swapped two wards to enable ring-fencing of elective orthopaedic admissions and an escalation area to open. Ward 19 and ward 18 swapped, ward 19 became ring fenced orthopaedic ward and ward 19 normally haematology and a private patient ward, became a mixed speciality area. During the inspection, we saw patients of all specialities both medical and surgical on the ward 18. This ward was linked to a medical consultant to ensure the medical patients were reviewed daily and surgical specialities reviewed their own patients.

Meeting people's individual needs

- The wards and surgical departments were accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available within the department if required and disabled toilets were available.
- The surgical services group reviewed patient's needs on admission, or during pre-assessment in regards to hearing difficulties or learning disabilities. An electronic flagging system alerted the matrons via an email identifying when and where a patient with learning disabilities was admitted or attending an outpatients appointment.
- The surgical group had an identified matron in surgery and day surgery to act as lead nurses for patients with learning disabilities and their carer's. There was no dedicated specialist nurse role.
- Translation services were available for people whose first language was not English, staff we spoke with were aware of how to access these services. Leaflets about the patient advice and liaison service were available in different languages.
- The surgical group used the butterfly scheme to identify and support people living with dementia; a blue butterfly was used on patients notes, handover sheets and patient boards. The trust had undertaken an audit on carers perceptions and experiences of care for patients living with dementia within adult in-patient areas September 2015. 35 responses were received and 25 carers said that their relative was on the scheme, 10 carers were not sure or said the scheme was not offered. An action of the audit was to improve knowledge of the butterfly scheme.
- The trust also used "my care plans" for patients living with dementia these care plans were completed with relatives to provide personalised care for patients.
- There were established links between specialist nurses and ward staff to ensure continuity of care and support for patients on discharge.

Surgery

Learning from complaints and concerns

- There were 15 complaints attributed to surgical services group December 2014 to December 2015. Themes included care and treatment issues (10 complaints), delay in treatment (4 complaints) and personal records (1 complaint).
- Data shared with us by the trust showed that six complaints were partially upheld, four were not upheld and two were upheld; we were unable to identify the status of three complaints. Learning was identifiable in three complaints and no learning was identified in eight complaints received; we were unable to identify whether learning had been identified in five complaints.
- The trust had a process that addressed both formal and informal complaints that were raised via the Patient Advocacy and Liaison Service (PALS).
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required.
- Staff talked to us about changes in practice that had occurred following a complaint, for example new consent checking procedures.
- Complaints were shared with staff via individual communication, safety briefings and handovers.
- Response letters to complaints that we reviewed included an apology when things had not gone as planned.

Are surgery services well-led?

Requires improvement

We rated surgical services at Airedale hospital as requires improvement overall because:

- The surgical services management team and senior nursing team were recently new in post and required more time to develop and become fully effective in their roles.
- Monthly governance meetings were in place however, attendance at these meetings had been poor. On most areas we visited, no ward meetings had occurred.
- We had concerns over the support provided to ward managers and confidence in the Matrons offered to the ward managers within the group.
- Ward managers were needed to provide clinical care on the ward and did not have capacity to take management time required for them to focus on management and administrative issues.

However, we also found:

- Surgical services group had a well-documented vision and strategy documents for use in surgical services group, however these were not always able to be identified on the wards and departments we visited.
- The inspection team were impressed with the leadership and dedication from the manager and staff working on ward 9. The team working in this area had recently won a number of internal awards.

Vision and strategy for this service

- An annual plan 2016/2017 was available for the surgical division. Achievements in 2015/2016 were identified, for example, reductions in length of stay for hip fractures from 21 days to 17, and the introduction of e prescribing and consultant recruitment. Areas not delivered were breast service recruitment.
- A programme charter was available for the surgical group; its aim was to develop a patient centred quality and safety and efficiency programme.
- The trust vision “Right Care” was used within surgical services the senior management team had identified aims to achieve in the following year for example, improvements in theatre scheduling and staffing and enhanced governance. Longer-term strategies for 2019-2020 were identified such as ward reconfiguration and surgical pathway redesign. Staff we spoke with were aware of the overall vision statement “right care at the right time for the right patient”, but were not always aware of the strategy and vision for the service.
- Staff had been involved in setting the values of the trust; however, it was noted in board minutes this required further embedding.

Governance, risk management and quality measurement

- The surgical care group was one of three care groups within the trust. The surgical services group held monthly governance meetings. We reviewed three sets

of minutes and noted items discussed included incidents, complaints and performance. Attendance was poor at these meetings, with apologies received from 50% of attendees at October and December meetings

- We reviewed minutes from surgical service divisional meetings and noted discussion was held about performance and finance. Attendance was improved at these meetings.
- An integrated performance dashboard monitored performance data was available and was discussed at the divisional meetings.
- We reviewed the surgical services group risk register; it reflected some current risks relevant to the operational effectiveness of the surgical group. However, clinical handovers, theatre recovery capacity issues or gaps in surgical junior medical staff rotas were not identified as risks despite the senior management highlighting most of these issues as risks during discussions. Risks identified had controls in place and actions taken. However, some risks had remained on the register for long periods.
- There was not an effective system to ensure policies and guidelines were updated and reflected national guidance.
- Surgical services had a clinical audit programme; audits undertaken were relevant to the surgical teams and the majority had been completed within the agreed timescales. Audit information was shared; however, changes resulting from the audit information were not always evident.

Leadership of service

- The surgical services group had a clear management structure; a new general manager had recently been appointed. Within nursing leadership, recent changes had occurred to senior matron, matron and ward leaders. Many of the staff in these posts were seconded and had been appointed in the months prior to inspection. This new structure required further time to be established.
- Ward managers were needed to provide clinical care on the ward and did not have capacity to take management time required for them to focus on management and administrative issues.
- There is a designated bed manager. The surgical group tried to ensure a senior nurse was on duty at weekends however, this was not always possible. The acute care team supported the junior ward managers.
- From our discussions with staff, staff were mixed in their opinions about the leadership within the surgical group. Junior staff we spoke with were positive about the leadership and support from ward managers and colleagues; senior nurses were concerned about the number of recent changes in leadership of the Matrons and the support they received. From our discussions with senior staff there was a lack of support and confidence in the matron structure. Some staff we spoke with did not always feel that if they raised concerns about the staffing levels being unsafe, the matrons listened to this.
- Most of the ward managers had not met the new deputy chief nurse or general manager for surgery.
- Matrons told us that wards held ward meetings, however on most areas we visited, no ward meetings had occurred.
- One of the wards we visited, ward 9, had previously been identified as an area of concern within the trust. The ward manager had worked with the ward staff to improve staffing levels, attitude of staff and general morale issues. The inspection team were impressed with the dedication and commitment of this member of staff and recognised that the team had recently won a number of awards.
- Senior nursing staff shared information and learning through nursing forums; these were attended by the chief nurse.
- Sickness absence within surgery for October 2015 was 4.9%; this was about the same as the trust absence rate of 4.6%.

Culture within the service

- Staff morale within the surgical services group was variable in most areas visited; staff told us that moving staff around to different areas was having an impact on morale. Some staff we spoke with also felt that they were expected to take overtime and to stay additional hours when their shifts had finished.

Surgery

- Some staff felt their concerns were not listened to or acted upon.
- Staff spoke about their immediate colleagues in a positive manner. Staff we spoke with were proud of the teams they worked in and the patient feedback they received, but they were aware that the care they provided was not always the care they would want to give. Junior nursing staff we spoke with said they felt supported by senior nurses.

Public engagement

- The NHS Friends and Family (FFT) showed a response at ward level as 35.5%. It was noted that this response rate was the same as the England average response rate.
- The trust completed a monthly carers audit to understand the hospital experience of people living with dementia.
- A programme charter was available for the surgical group. From information we reviewed, it stated that a patient representative was on this group, however the senior management team confirmed that this was not the case at the time of the inspection.
- Staff we spoke with told us that patients had attended the nursing and midwifery forum to share their experience.
- Some wards displayed a "you said, we did" board, thank you and compliment cards sent by patients and relatives.

Staff engagement

- Ward and department managers we spoke with told us about an "open door policy" for staff to discuss issues with them.
- The current response rate in the trust to the NHS staff survey was 31.7%; surgical services responses were slightly lower than the trust rate at 26.7%.
- The trust used a winter champion's social media messaging system to highlight wards and departments requiring additional assistance.
- The trust had recently run a "you said we did" campaign for staff were staff could highlight issues in a "silver box" and receive feedback on actions to be taken. Staff we spoke with said that many good ideas had come from that initiative, for example afternoon tea with patients. However, staff did tell us they were still awaiting feedback on many of the ideas generated.

Innovation, improvement and sustainability

- The surgical services group identified that improvements had been noted in the Maxillofacial pathway due to the development of a specialist nurse working in this field.
- The trust had introduced advanced nurse practitioner and advanced practitioner in orthopaedics outpatients.
- In the recent pride of Airedale award, ward 9 won the team of the year award, the leadership award and the volunteer of the year award. They were also commended in the colleague of the year award.

Critical care

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

Information about the service

The Critical Care Unit (CCU) at Airedale hospital has fourteen beds and encompasses intensive care, high dependency and coronary care units. The Intensive Care Unit has three level 3 beds and four level 2 beds. Beds were used flexibly to accommodate the needs of the patients. The unit provided care and treatment of acute and critically ill patients who required cardiac, respiratory, renal and other organ support.

The Acute Care Team (ACT) provides 24 hour support to ward staff following discharge from the critical care unit. ACT is comprised of nurses who are advanced nurse practitioners, they responded to deteriorating patients on the wards.

Between1 April and 31 December 2015, there had been 479 admissions to the unit, 390 patients were discharged home, and 88 patients died either on the unit or on the wards. The number of patients' survived following admission to the CCU was similar to the same size units in the country. We collated this information from the intensive care national audit and research centre quarterly case mix programme report.

Following our inspection in March 2016, we were informed of a serious incident that had occurred on the critical care unit. 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.

Summary of findings

We rated the core service as requires improvement because:

- Safety was not given sufficient priority. Opportunities to prevent or minimise harm were missed. We identified examples where proactive measures had not been taken to prevent recurrence or minimise risk following reported incidents.
- There were substantial and frequent staff shortages. Nurse staffing levels for the unit consistently fell below safe levels, staff appraisal of their work performance was low and the number of staff trained on post registration training in critical care nursing was below the recommended minimum numbers.
- Staff were not allocated sufficient time to fulfil their role specific duties such as the clinical nurse educator and the clinical coordinator as staff were expected to deliver hands on care and at the same time fulfil their additional responsibilities.
- We found that multidisciplinary ward rounds did not comply with national guidance and arrangements for medical staff handovers at shift changes were not formal.
- Patients well enough to leave the unit experienced delays due to insufficient beds on the wards.

Critical care

- Patients who had been on critical care unit did not receive any formal follow-up in rehabilitation and emotional support once they were discharged from the hospital into the community.
- Sharing of information between senior managers and the front line staff was not effective. Staff did not have regular staff meetings in their unit and there was a lack of formal information sharing. There was a lack of monitoring of progress by the matron.
- 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.

However. We also found:

- There was a designated consultant review of all new patients within 12 hours of admission.
- The unit was kept clean and visitors and staff had access to hand washing facilities to promote infection control.
- Priorities and values of staff underpinned their mission 'here to care'.
- Patients and relatives were very appreciative of the care delivered on the unit.

Are critical care services safe?

Inadequate

We rated the service as inadequate for safety because:

- Safety was not given sufficient priority. Opportunities to prevent or minimise harm were missed. We identified examples where proactive measures had not been taken to prevent recurrence or minimise risk following reported incidents.
- Where changes were recommended following incidents, there was no system to monitor whether staff were aware of the changes and whether these were maintained to avoid them happening again.
- There were substantial and frequent staff shortages. Staff shared with us their anxiety and distress about working in an environment where there was insufficient number of staff. Staffing levels on the unit consistently fell below the safe levels recommended by the Core Standards for Intensive Care Units published by the Intensive Care Society (ICS) and the British Association for Critical Care Nursing (BACCN). Therefore potentially putting patients' safety at risk.
- Consultants were present between 8am and 6pm at hospital , and 6pm and 8am the following day they provided on call cover.
- Consultants covered one 24hr shift. This was contrary to Faculty of Intensive Care Medicine (FICM) workforce advisory group recommendations that consultant work patterns should deliver continuity of care. A shared care model was being implemented.There were insufficient intensivists deployed, although the trust recognised this and were actively recruiting.
- Systems and processes for medical staff handover were not formalised. The handover was not patient centred, but a general brief about the overall anaesthetic plan for the day across theatres, obstetrics and the intensive care.
- Following our inspection in March 2016, we were informed of a serious incident that had occurred on the critical care unit. We carried out a further unannounced inspection which highlighted the insufficient action taken by the management to prevent recurrence of incidents. Consequently, we met with the Chief Executive to gain assurance that additional actions were taken to ensure safety.

However, we also found:

- Patients' records demonstrated a personalised care and treatment approach. There was a designated consultant review of all new patients within 12 hours of admission.
- Areas occupied by patients and the clinical areas within the units were clean.
- The unit had a good track record in relation to the prevention of falls, infections and pressure sores.
- Medication was administered in a person centred way and appropriate checks were carried out beforehand by nurses to maintain safety.

Incidents

- We received information from the trust, which showed that there were no never events between October 2014 and September 2015. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- National Reporting and Learning System (NRLS) enables the public including professionals to upload patient safety information. The National Reporting and Learning System (NRLS) records highlighted five incidents between December 2015 and March 2016 that the trust had reported as causing no harm to patients. Although no harm occurred, there was no proactive action taken to minimise any further risk of harm. 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. For example, patient interventions had to be prioritised, staff were unable to carry out the necessary safety checks, patients were not turned as frequently as needed, staff were unable to watch telemetry at all times as staff were not near the monitor. We found these incidents had a negative impact on patient care and could have caused harm to patients.
- We found the number of incidents reported compared to similar services in the UK was low. Therefore following our inspection we requested information for a 12 month period. The trust provided data between December 2014 and November 2015 and there were 243 reported incidents
- The most frequently reported incident category was clinical care. All incidents in this category was reported as resulting in no harm.
- There were three incident categorised as resulting in moderate harm. They were 'implementation of care and ongoing monitoring/review'.
- Nearly 50% of low harm incidents were also classed as 'implementation of care and ongoing monitoring/ review'. The majority of incidents (83%) were reported to NRLS over the 60 day recommended time. Only six incidents were reported within 14 days.
- We spoke with staff about their understanding of Duty of Candour. Four staff told us that they had not heard of it. The matron said it was being open and honest when they had made a mistake and let people know. Two nurses said it was admitting to patients and relatives when mistakes happen. We did not see any training to staff on the principles and requirements of Duty of Candour and its application within the trust.
- Staff had access to an electronic system to report incidents. Staff were familiar with the system and they were confident about when they should report incidents, including serious incidents and never events.
- We saw how incidents had been reported, investigated and how lessons learnt had been recorded. The report was signed off by designated managers once the action plans were agreed.
- We saw the notes from the Medical Devices Group meeting on 16th December 2015 where issues such as an incident involving ventilator tubing; this was deemed as a minor user error and that it posed no risk to the patient. However, staff involved have been given supportive training to help avoid a repeat. Other issues discussed at the meeting included the on-going concern over the telemetry system, lack of wheelchairs for patients and a review of blood pressure monitoring machines.
- The matron explained that the outcome of incidents and the action plans were shared with Band 7 staff at staff meetings and they expected the information to be cascaded to all other staff on the unit. However, they did not have a system to monitor staff awareness of the information and whether the changes implemented were maintained by staff to avoid incidents happening again.
- Staff on the unit informed us that there had been two serious incidents relating to pressure ulcers. They said that they had reviewed their practices and added further columns to the observation charts so that specific checks were carried out regularly to avoid it happening again. We saw the records on the charts.

- We reviewed documents that showed the processes for escalating information to relevant people so that appropriate decisions were made. The matron informed us that all incidents were discussed at the quality assurance meeting, chaired by the Group Senior Matron so that the issues could be shared amongst other matrons and learning could be cascaded within directorates.
- We observed the investigations by the matron adhering to duty of candour regulation, including examples of written apologies.

Unannounced inspection on 11 May 2016

- Following our inspection in March 2016, the Trust informed us of a serious incident that had occurred on the critical care unit. The trust provided information on their initial actions following the incident which included a two person check on the ventilator equipment. On further analysis of this and other evidence, we undertook an unannounced focussed inspection. We found that four staff we spoke to were aware of the new process but there was not a consistent approach to documenting the check embedded on the unit. There were no documented checks for any patients who were ventilated at the time of the unannounced inspection. No monitoring had been undertaken to provide assurance to the trust that the checks were undertaken as planned. One of the directors was asked to provide assurance regarding the equipment checks. This was not provided. Consequently, we spoke with the Chief Executive to gain assurance that additional actions were taken to ensure safety.

Safety thermometer

- Safety thermometer information was displayed on the unit. This meant staff, patients and visitors could see the incidence of harm free care.
- One catheter associated urinary tract infection and two pressure ulcers were reported between September 2014 and September 2015.

Cleanliness, infection control and hygiene

- We found the areas occupied by patients and the clinical areas within the units were clean and free of offensive odour. Other areas such as the store rooms, the sluice, administration areas, staff station and relatives waiting areas were also found to be clean.
- Sharps bins we saw were less than 1/3 full and all bins in use were dated and signed by a member of staff in line with the local policy.
- During the tour of the unit, we observed stickers on areas and equipment to indicate the date they had been cleaned.
- Regular cleaning was carried out by nurses. We viewed the cleaning logs used by nursing staff, included equipment in use by patients and patient bed areas.
- We were informed by staff that they were responsible for cleaning equipment and this was audited by the matron and reported to the infection prevention lead nurse for the trust. However, we were unable to access any completed audits and the matron did not have an action plan on the findings of the audits. They explained when they found gaps, they discussed them with the staff and rectified them immediately. There were no formal checks for monitoring staff compliance.
- Staff training on infection, prevention and control, compliance on 17 March 2016 was identified as 88.9%. This was above the trust's internal target of 80%.
- We observed staff adhering to infection control policy and using personal protective equipment (PPE) when delivering personal care. Staff told us they had access to PPE and other disposable consumables.
- There was antiseptic wash available to all visitors and staff. We observed people entering and exiting the unit, decontaminating their hands by using the wash.
- Family members we spoke with told us that staff wore PPE when caring for their relatives and changed them once they had completed the task.
- Staff also carried out a global audit each month as part of their safety audit and the findings were displayed for staff and visitors to see. The results for February 2016 were,zero number of patients treated with Methicillin-resistant Staphylococcus aureus (MRSA), zero number of patients identified with Clostridium difficile (C.Diff) and no new catheter associated urinary tract infections.
- Two staff nurses we spoke with were well aware of the policy for prevention of infection.
- Intensive Care National Audit & Research Centre (ICNARC) data confirmed that there had not been any patients with Clostridium difficile this year. Care records we reviewed showed that patients admitted to the unit had their MRSA status checked. Trust information confirmed that during 2015 patients admitted to the CCU did not have MRSA.

- There was a side room within ITU which made the fourth bed area for the ITU. We were informed that this room was used as an isolation room. However, this was not equipped with negative room pressure to prevent cross-contaminations from the isolation room to the other patients in the unit in accordance with 2007 Guideline for Isolation precautions. We were told that patients using the isolation room were mostly immunocompromised and needing protection from infections.

Environment and equipment

- ITU provided a mixed sex accommodation. The main ITU had three bed spaces each separated by curtains and a side room. HDU has two two-bedded bays and two side rooms. . Staff told us that most of the time single sex accommodation was able to be offered to patients. In total, there were seven beds on the critical care unit. Areas away from patients were cluttered due to the lack of storage space. This was highlighted in the risk register by staff so the head of nursing and other senior managers were aware of this.
- Coronary care beds had been used flexibly when there was a need for additional high dependency beds.
- There were windows in ITU where patients were able to orientate themselves to the place and time. This helped patients manage the symptoms of delirium.
- Staff told us that requests for new and/or replacement equipment were authorised by their matron without delay. We noted that patients had access to up to date equipment for example the unit had purchased four new ventilators for patients' use.
- We saw the electronic equipment log held by maintenance / technical department away from the unit. The technical officers informed us how they ensured timely maintenance was carried out and how they had a rolling programme for replacing equipment. They explained that they were responsible for the maintenance
- We noted that the equipment we saw had stickers in place stating the date they had been serviced or electrically tested.
- A resuscitation trolley with equipment was kept within easy reach of staff on the unit. We noted from the records that each day the resuscitation equipment had been checked and signed by staff. Managers told us that resuscitation equipment was regularly checked by the resuscitation officer and records were available to confirm this.
- The clinical educator and the medical equipment technician told us that they were responsible for ensuring device availability and that they were compliant with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance.
- During the inspection, we observed there was insufficient storage space for equipment and stock items. We noted that one of the shower rooms for staff was used as a store room .We observed there was insufficient storage space for equipment and stock items. We discussed this with the nursing team who told us they used areas, such as the staff room and one of the staff toilets, for additional storage. They said this was an ongoing issue as staff facility for washing or showering was no longer available and it had been raised as a risk.
- There had been an incident this year, 2016 where staff from the unit went to assist a patient who was being monitored through telemetry on a ward. On arrival they found out that the patient had been moved to a different ward which they were not made of aware of which delayed the intervention to the patient.

Medicines

- The systems in place for the management of medicines demonstrated compliance with the medicines act 1968 and the Misuse of Drugs Act 1971.
- We observed staff ensuring that patients had their medications administered at the times they had been prescribed.
- Medication was administered in a person centred way and appropriate checks were carried out beforehand by staff to maintain safety.
- Five Medication Administration Records (MARs) were reviewed and we found them to comply with the national prescribing guidelines. Allergies were clearly documented in the MARs together with patient's name, hospital number and date of birth.
- We noted the reason for omission of medicine was clearly documented on the MARs.
- We spoke with a senior pharmacist who was present on the unit, about their role and responsibilities. They said that they played an essential part in optimising the patient's medication; they carried out regular reviews of

the stock drugs on the unit and attended the unit twice daily between Mondays and Fridays. They said that there was an on call pharmacist who was in the hospital for advice at the weekends and during national holidays.

- The pharmacist informed us that medication compliance in the unit was audited regularly and the results shared with staff. They told us that each month they carried out a controlled drug audit, medicine and custody audit and also checked on defined daily doses of medicines (DDD). Three staff we spoke with confirmed that it happened. We saw a copy of the latest audit.
- Controlled drugs (CD) were handled appropriately and stored securely. We carried out a spot check on the CD stock and records maintained by nurses and found them to be accurate. We observed nurses carrying out medication administration. We saw appropriate checking, administration and recording of medication by nurses.
- Local microbiology protocols for the administration of antibiotics were in use. We observed a microbiologist visit the unit and check patient notes. Staff informed us that this was carried out during the week and if there were issues the microbiologist spoke with the doctors.

Records

- Patients' medical notes were kept in trolleys near the reception. Although visitors had to get permission to enter the unit they were able to move around the unit freely, therefore had access to the notes of any patient. During our inspection we observed on five occasions the station was not staffed and the patients' notes were left unattended in the trolleys. This meant patients not all notes were securely stored on the unit to maintain patient confidentiality.
- Records were held in electronic and in paper format.
- Nursing staff had attended training on information governance and records showed staff attendance was 67%.
- We reviewed ten sets of patients' records. Hard copies of patients' files contained multi-professional notes. Patients' records included decision to admit to intensive care, individual care plan, risk assessments, daily progress, reviews and consent to treatment. Records we reviewed were legible, filed in chronological order and met the Guidelines for the Provision of Intensive Care Services (GPICS) 2015 and professional standards.
- The records demonstrated a personalised care and treatment approach. It was noted that there was a designated consultant review of any new patient in ITU within 12 hours of admission and a treatment plan for the patients was written following the review in line with the GPIC Standards.
- There was written evidence of regular communication with relatives and patient's representatives by professionals.
- We visited three patients on the wards who had been transferred from the critical care unit and viewed their records. Appropriate forms had been completed to ensure information was passed on to ward staff. There was evidence that the Acute Care Team (ACT) who carry out outreach activities had also seen the patients.

Safeguarding

- There was a policy on safeguarding vulnerable adults and children on the unit.
- The staff we talked with demonstrated a good knowledge of what safeguarding meant in practice and they were able to tell us the escalation process to raise any safeguarding concerns.
- The matron informed us of a safeguarding referral which was made in the last 12 months, the action they took and the process of investigation. They had taken immediate measures to protect patients and staff as soon as they were made aware of the matter. The outcome of the investigation was shared with us to show that they had followed the correct procedures.
- There was a trust lead for safeguarding and staff told us how visible that person was and how they had supported them when they had approached them for help.
- The clinical educator played an integral part in making sure all staff complied with attending safeguarding training. We noted that staff allocated to ITU were 100% and HDU 80% compliant with safeguarding training and updates against a trust target of 80%.
- Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said staff looked after them well and they felt safe on the unit.

Mandatory training

- We requested statutory and mandatory training records for the staff including medical staff working within the critical care unit. We were informed by the matron that the trust target for training compliance was 80%.
- Compliance with training for nursing staff was Staff and Patient Safety (Quality & Safety) 94.4%, Mental Capacity Act training 94.4%, Manual Handling Update (People) 63.9%, Infection Prevention (Level 2) 88.9%, Fire Safety 91.7%, Dementia Awareness (incl. Privacy & Dignity standards) 94.4%, Conflict Resolution 75%, Blood Transfusion 100%, Basic Life Support 86%.
- The frequency of the training differed between one and three years depending on the trust policy.
- Nurses and health care assistants told us that most training was computer based and the training co-ordinator ensured that they were allocated time slots to do their training and they encouraged them to become compliant.

Assessing and responding to patient risk

- We saw elective patients had a comprehensive risk assessment as part of their preparation for admission to ITU. We were informed when a patient was admitted as an emergency to the unit, staff carried out patient's risk assessment whilst the patient was on the unit. We observed the risk assessments were reviewed and amended according to the changing needs of the patients.
- We looked at three patients' records and noted that on admission patients received an assessment for venous thromboembolism (VTE) and a clinical risk assessment on bleeding. We were informed by the medical staff that, if identified as needing treatment, relevant care bundles were used according to their local policy.
- The records showed that risks were managed positively. Staff gave us two examples where risk assessments had highlighted the risks to patients and how they had taken action to minimise the harm to the patients. These were a patient was on oxygen through a face mask, therefore at risk of the mask causing soreness on the face and a patient who was intubated being at risk of developing pressure damage due to the endotracheal tube resting on the patient's lips. These risks were identified and action taken to avoid unnecessary harm.
- There was a hospital wide standardised approach to the detection of deteriorating patients and a policy on documentation, escalation and response. National Early Warning Score (NEWS) was in use on the wards. Staff on the unit told us that they informed ACT of all discharges to the wards and this was documented. We visited three patients who had been transferred from critical care unit on to the wards. On the wards we noted staff using NEWS and escalating the information on to the Acute Care Team (ACT) of nurses.
- ACT comprised of nurses with advanced practice skills, supported by health care support workers. They were authorised to prescribe fluids, oxygen, take blood from central line and Hickman line and care for central lines on the wards. The ACT responded to raised NEWS scores, started non-invasive ventilation (NIV) or high flow Oxygen, followed up all ITU and HDU patients aiming to see them within 6 to 8 hours. ACT provided 24 hour support to ward staff.
- We interviewed three ACT nurses who informed us that they prioritised their work each shift and saw patients according to their needs. They shared with us their work load for the day/night and how they used the NEWS score and information from the ward staff to prioritise their visits.
- The medical and nursing staff informed us that they were able to provide level 3 support to four patients on the unit. All admissions to ITU were authorised by a consultant.
- Shared care was provided by certain areas. This meant that Obstetrics and Gynaecology consultants managed and co-ordinated their patients' care on the critical care unit and had access to the anaesthetists.

Unannounced inspection on 11 May 2016

- Six ward patients' telemetry was monitored on the unit. We observed the telemetry screen was not monitored constantly by staff. Staff on the unit told us they did not have time to monitor the screen constantly. We visited the patients who were being monitored on the ward; there was no monitoring facilities on the wards. Staff on the wards understood the patients were being monitored remotely and told us critical care staff would phone the ward if there were any changes on the telemetry.
- An incident occurred in May 2016 at night where a ward patient whose telemetry was being monitored on the unit had a cardiac arrest. Staff on critical care could not contact the ward staff using the telephone so walked down to the ward to inform staff.
- The incidence of patients requiring a tracheostomy had reduced and medical staff had expressed concerns

about staff on the unit who had not cared for a patient with a tracheostomy. A record was not kept of how many staff had completed their tracheostomy competency training. We were told by a senior member of staff it was approximately 20 out of 35 staff; dates of when the competencies had been completed were unknown.

- A patient with a tracheostomy was moved to a side room on CCU to allow an emergency level 3 patient to be admitted to the unit as there was only two nurses in the ITU side of the unit.

Nursing staffing

- Staff on duty informed us that they had a set staffing level for the three areas (which included Coronary care unit). In total, when the units were full they had a planned staffing level of seven qualified nurses and two health care assistants during the day which was 8am until 8pm and between 8pm and 8am seven qualified nurses. The numbers were reduced when they had fewer patients and staff were moved to other areas of the hospital.
- Managers including the matron informed us that they did not use any acuity tool when deciding on staffing levels. They said staffing had been set for a number of years and based on the availability of staff.
- They also clarified that this staffing level was when the unit had three level 3 patients, four level 2 patients and seven coronary care patients.
- The European society of cardiology (ESC), the British Association for Critical Care Nursing (BACCN) and the GPICS recommend that patients in intensive care should have one qualified nurse to one patient and others including coronary care and high dependency patients should have one qualified nurse to two patients. This meant the Critical Care Unit at Airedale general hospital when full should have eight to nine nurses on duty during 24 hours to comply with the ESC, BACCN and GPICS. We found the planned staffing levels were not consistent with safe staffing levels according to national guidance.
- Data supplied by the trust for CCU between April 2015 and January 2016 showed that planned staffing whole time equivalent (WTE) was 75.6 and the actual WTE was 70.5. This meant there was a deficit of -5.1 which came to -6.8%
- Bank nurses usage between April 2015 and January 2016 for CCU ranged between 0 – 0.8 % and averaged 0.4% over the ten months.
- During our inspection patients, relatives and staff said that the unit was busy and it did not have sufficient staff during days and nights.
- People said that they could see staff were rushed and they avoided asking for help such as pain relief, help to have a drink and to be moved to a more comfortable position. Our observation on the days of the inspection confirmed this.
- Staff told us that they were anxious and distressed as they were over worked due to insufficient staff.
- The staff rota was held electronically and was accessible to bed managers and matrons. Staffing figures were updated as changes were recorded such as sickness and absenteeism. Therefore, the matrons and senior managers had access to the staffing on the unit and the wards.
- We saw a paper record labelled 'critical care unit safety breach'. This was completed by nurses on each shift and the records were kept on the unit. Staff told us that the matron referred to the information when they were on duty to check the capacity. The information recorded on the form included, number of patients on each area, staff numbers on shift, movement of staff, the times they were away from the unit and any risks identified by staff on the shift, such as having to accommodate mixed sex cubicles within the unit due to bed shortage.
- We looked at the bed occupancy status and the actual nursing staff levels over the 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 GPICS and on this day there were no ITU patients on the unit. At the time of inspection, we requested the previous three months duty rotas (December 2015 to end of February 2016) with actual staffing numbers. The trust provided data from 16 November to 31 December 2015. This period covered 46 days i.e. 92 shifts. The data highlighted during this period, for 17 shifts sufficient number of nurses were deployed. This demonstrated that 81.5% of the shifts did not have sufficient number of nursing staff on duty in accordance with national guidance.
- We were informed by staff that they were expected to work on any of the three areas and staff allocation did not consider individual staff skills, experience or speciality knowledge. They said that one shift they

would work with patients in coronary care, the next on intensive care and the third shift on high dependency unit. This caused a lack of continuity of care for staff and patients.
- We observed nursing hand over which was carried out in a structured way, where appropriate information was shared. Handover happened twice daily when nursing staff shifts changed. There was a general handover in the staff room among all staff coming on duty from the shift manager and individual patient hand over took place at the patient bedside between the nurses. This included patient participation.

Unannounced inspection on 11 May 2016

- At the unannounced inspection, we found the nursing coordinator was not supernumerary. This was not in line with recommendations from the guidelines for the provision of intensive care services (2015). A member of unregistered staff from the acute care team worked on the unit as part of the nursing escalation process; they had not worked on the unit before and had not received an induction on the unit.
- Staff on the critical care unit reported they used an allocation book to identify which staff cared for which patients on each shift and staff told us this was the most accurate picture of staffing on the unit. During our unannounced inspection we reviewed the allocation book and off-duties and found on a number of occasions the numbers of staff working on the unit did not match.
- At the time of inspection, we received whistleblowing information which raised concerns regarding staffing levels on the unit.
- We found staff had been moved from the critical care unit to work on other wards in the hospital on 20 occasions between 28 March and 11 May 2016.
- We undertook a further review of nurse staffing from 28 March 2016 to 11 May 2016. We found that planned staffing on the unit to care for a maximum of three Level 3 patients, four Level 2 patients and seven CCU patients was seven registered nurses on every shift. Over the 45 day period the actual number of nurses which met the planned number were 21 early shifts, 16 late shifts and 11 night shifts.
- Over the 45 day, period 36 (80%) early shifts, 34 (75%) late shifts and 32 (71%) night shifts the actual number of registered nurses met the number of registered nurses required on the unit according to trust guidance.
- Over the 45 day period seven (1.5%) early shifts, five (11%) late shifts and four (8%) night shifts the actual number of registered nurses met the number of registered nurses required on the unit according to best practice guidance (GPICs, RCN and BACCN guidance).
- From 28 March to 10 May 2016, we saw that there had been four incidents reported regarding staffing levels and impact on patient care on the critical care unit. For example, on 1 April 2016 there was one registered nurse to provide care for one level 3, one level 2 and a level 1 patient. It was reported that a patient pulled off their oxygen mask resulting in deteriorating blood oxygen levels, and they pulled out their intravenous line. On 28 April 2016, an incident form was submitted through the trust system, which recorded there was one registered nurse to care for one level 3 patient and a level 2 patient who was “very unwell and potential to become level 3”, two patients required registered nurse escorts to other hospitals and a nurse came in from home to provide an escort for one of these. A registered nurse was sent from a medical ward to assist on the critical care unit. Two further incidents were recorded in May 2016 which indicated low staffing levels which resulted in patients not being repositioned on time, medication being given late and routine checks not being completed. Three of the incidents occurred following the serious incident on 19 April 2016.
- In May 2016, the nursing and midwifery staffing exception report paper to the board reported for April 2016 an 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 as detailed above.

Medical staffing

Critical care

- Consultants at Airedale hospital CCU did not work 24-hour block shifts; instead they covered just 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.
- Faculty of Intensive Care Medicine (FICM) workforce advisory group recommend that consultant work patterns should deliver continuity of care and that the majority worked 5 day blocks of day shifts on ICU. Such arrangements reduced burn-out in intensivists and maintain the same patient outcomes as 7 day blocks.
- The first on call for out of hours cover was provided by a CT1 or CT2 or a middle grade. Guidelines for the Provision of Intensive Care Services (GPICS) 2015, requires that a consultant in Intensive Care Medicine must be immediately available at all times and be able to attend within 30 minutes. We were assured that all consultants on call were able to get to the unit within 30 minutes.
- During our inspection the unit was covered by a consultant anaesthetist who was not a regular critical care consultant and only provided cover when required. They told us that they had provided cover on a regular basis and therefore knew the hospital and the consultant colleagues.
- The department of anaesthetics had 16 consultants, 10 middle grades, and six specialist trainee (one CT3, two CT2 and three CT1) doctors. In common with many organisations, recruitment continued to be a challenge for this trust and there was reliance on bank and agency staff to meet staffing needs.
- The locum usage in CCU between April 2015 and January 2016 averaged 12.7% and in August 2015 the usage increased to 23.5%.
- A standard working day in critical care included a consultant, a first on call who may be a CT1 or CT2 Trainee doctor and the second on call was a middle grade doctor or CT 3. However, during the day the first on call was in theatre and directly supervised by the consultant therefore the second on call provided cover for both obstetrics and critical care.
- Arrangements in place for medical staff for handovers and shift changes did not comply with the GPICS guidelines to ensure patients' safety since handover did not happen at the patient's bedside. GPICS stipulate that consultant intensivist should lead a multi-disciplinary clinical team ward round within intensive care and it must occur every day including weekends and national holidays and such ward rounds did not occur on the unit.
- The handover took place at 8am every day in the recovery area away from the unit. This daily generic handover included a discussion of the critical care patients by the middle grade covering the previous night to the consultant and middle grade in charge for critical care for the day. The handover was not patient centred but a general brief about the overall anaesthetic plan for the day across theatres, obstetrics and the intensive care. At around 9am a more detailed ward round was conducted by the consultant Intensivist in the critical care unit without the previous night team and this was not conducted at patient's bedside but at the central patient's name board.
- After the unannounced inspection we spoke with the medical director who confirmed the trust has sought to actively recruit anaesthetists who fulfil the FICM definition of an intensivist and currently employs 5 WTE consultants who fulfil the FICM criteria.

Major incident awareness and training

- Staff had access to the trust's major incident policy and the procedures. They said that they had received training on major incident awareness.
- Staff knew their role in managing a major incident. This included multidisciplinary staff.
- Managers said that they had business continuity plans and knew who they should contact.

Are critical care services effective?

Requires improvement

We rated the service as requires improvement for effective because:

- Multi-disciplinary clinical ward rounds within critical care did not happen in accordance with national guidance.
- Patients on the unit did not have access to an identified dietitian as recommended to provide continuity of care.
- All staff should have a manager's appraisal of their work performance every 12 months but only 54.3% of nursing staff had had one.

- At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 38% of nursing staff.
- The clinical nurse educator could not perform their specialist role as they were counted as a member of the team providing patient care.
- The unit used telemetry equipment to monitor the heart rhythm of patients on wards remotely and send information to a screen in the unit. However, staff were not available to monitor the data and respond in a timely manner so that the information was effectively used.
- We found some evidence-based guidance was overdue for review.

However:

- Staff used a pain assessment tool asked patients if they were comfortable and offered them appropriate pain control.
- Intensive Care National Audit & Research Centre (ICNARC) findings showed that the outcomes for people in the unit were similar to comparable services.
- The handover document used when transferring patients from the unit complied with NICE guidance.

Evidence-based care and treatment

- The multidisciplinary staff team were mindful of their responsibility to assess, plan and deliver the most appropriate treatment in line with evidence-based guidance. This was noted during our discussions with staff and from the records we viewed. Staff informed us of the care bundles used to standardise procedures, for example the ventilator care bundle.
- We were informed by staff and the managers that they worked closely with the West Yorkshire critical care network and attended meetings and shared knowledge and experience.
- The matron and two medical staff informed us that the policies and procedures were based on NICE and Royal College guidelines and they were updated regularly.
- We checked the hard copies of the following policies and found they did not have review dates or dates showed for renewal had expired.
  - Sedation hold – no review date
  - Epidural infusion – review April 2015, expired
  - Continuous renal replacement therapy (CRRT) – review date 2010, expired
  - Bowel care – no review date
  - Delirium - review date 2014, expired
  - Arterial line- review May 2014 expired. These documents were available to staff at the central station for reference. We shared our findings with the matron who told us the policies were regularly updated and staff were expected to refer to the policies on the computer.
- One of the critical care consultants had been involved in developing guidelines to comply with Intensive Care Society standards and policies. They said admission and discharge of critical care patients, sedation holds, delirium guidelines, central line insertion and maintenance bundle had been developed. They said once guidelines were reviewed and ratified they would be placed on share point so all colleagues would be able to access them.
- We viewed the monthly critical care core group meetings and the acute care team meetings, at the last meeting in February 2016, the need to review all policies was discussed.

Pain relief

- We spoke with patients and their family members about the comfort of patients and the pain control facilities on the unit. We had a positive response assuring us that staff treated pain and kept patients comfortable on the unit.
- Staff used a pain assessment tool as well as speaking to patients and asking them if they were comfortable and offered them appropriate pain control. Staff used signs/ non-verbal communication to take with patients who were intubated and unable to vocalise their wishes.
- Medication administration records demonstrated patients' pain had been regularly assessed and changes were made to the treatment by the doctors.
- We spoke with a consultant anaesthetist about the arrangements for managing pain relief in the critical care unit. We also asked whether they were compliant with faculty of pain medicine core standards for pain management. They explained that the guideline stated that there should be one programmed activity (PA) per week by the consultant anaesthetist but at Airedale there was 0.5 PA per week. They said that the sessions were satisfactory for the size of the hospital and the patients they had responsibility for.

- They said their audits on 'patient satisfaction' with the management of pain was high and this was confirmed by patients we spoke with. We requested the latest pain management audit results; we were informed that the audits were not formal.
- As part of preventing pain staff used epidurals on the HDU and on the wards.
- The nurse specialist in pain management was on leave during our inspection. The anaesthetist told us that the nurse specialist supplied them with up to date guidelines and was available Monday to Friday to support the patients and staff.

Facilities

- Telemetry monitoring was used on the unit and also to monitor patients remotely on the wards.
- Telemetry monitoring is when the electrical activity of a patient's heart is observed for an extended period to identify problems with the heartbeats.
- Within the critical care unit at the reception area a telemetry monitor was placed so that staff on the unit were able to carry out monitoring.
- On two separate days when we visited the unit we observed abnormal heart rhythms from patients on the wards. The alarm was on and staff were not around to take action. We prompted staff on both occasions and they took action by calling the ward. However on one occasion staff were unable to contact the ward staff so one of the staff members from the unit had to go on to the ward to alert staff.
- We shared our findings with the matron. They informed us, that the telemetry monitoring was the responsibility of the care co-ordinator on each shift and they were expected to maintain a record of their observations. We saw that monitoring took place intermittently.
- Staff confirmed that often the care co-ordinator was counted in the qualified staff numbers for the shift and did not have the time to attend to the telemetry monitor. Staff had raised their concerns with the matron and the matron acknowledged that they were aware of the issues relating to Telemetry monitoring.

Nutrition and hydration

- We reviewed ten patients' notes during our inspection. We found that patients had assessments of their nutrition and hydration needs and depending on the outcome patients had been referred to the dietitian. We saw suggested feeding regime by the dietitian on patients' notes.
- Nurses told us they received good support from the dietetic department.
- Two patients and three relatives said they had been included in the planning of nutrition/diet.
- We observed a dietician chatting to a patient and their relatives, answering questions offering them choices of food.
- A dietitian told us that all patients on the unit were screened using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening **tool** to identify adults, who are malnourished, at risk of malnutrition, or obese.
- They said if the outcome triggered a referral, an in-patient referral form was completed by the nurses on the unit and faxed to the dietetic department where high risk patients were seen within 24hrs.
- They informed us that they did not have a dietitian as part of the critical care multidisciplinary team who took on the responsibilities; therefore the critical care unit was visited as part of their general workload.
- They told us that they did not provide cover at weekends and bank holidays, but they said that the nurses on the unit had been provided with emergency and out of hour's parenteral feeding regime.
- We found the unit was in breach these recommendations in the Guidelines for the Provision of Intensive Care Services 2015. They did not have an identified dietitian and they did not get involved in the MDT.
- Guidelines for the Provision of Intensive Care Services 2015 recommendations for the role of the dietitian for critically ill patients include that;
  - There must be a dietitian as part of the Critical Care multidisciplinary team.
  - The ICU lead dietitian will be involved in the assessment, implementation and management of appropriate nutrition support route, in collaboration with the rest of the multi-disciplinary team (MDT).
- Patients were offered food supplements when they had not taken sufficient nutrition. Food and fluid charts were recorded and retained by staff to monitor food intake and fluid balance. We looked at four charts and they had been regularly recorded.

Critical care

Patient outcomes

- We found out that there was a nurse, supported by a clerical staff responsible for routinely collecting information about the outcomes of peoples' care and treatment on the unit and submitting the information to the relevant authorities.
- This included Intensive Care National Audit & Research Centre (ICNARC). ICNARC findings showed the areas where the outcomes for people in this critical care unit were similar to comparable services; therefore remained within the nationally expected ranges. The areas included mortality of patients, unit acquired MRSA, un-planned readmission to the unit within 48 hours and non- clinical transfers out of the unit. However there were some areas which fell below expectation. They were out of hours discharge to the ward and delayed discharges (over 12 hour delay) potentially having a negative impact on patients' outcomes.
- Monthly reporting referred to as 'global measures' were submitted to the West Yorkshire adult critical care operational delivery network. The report for February 2016 provided the following data which highlighted the patient experience and the outcomes.
  - Number of Patients with MRSA Bacteraemia – 0, Number of Patients with C. Diff - 0
  - Average occupancy : Level 2 Occupancy was 180% and Level 3 Occupancy % 67%
  - Discharges to the wards in the month were 42 patients of which four patients were transferred out of hours i.e. between 22:00 & 06:59.
  - No readmission within 48 hrs to critical care from a ward area
  - However a total number of 900 hours were lost this month due to delayed discharges. Delay identified when 4 hours after bed was requested.
  - During this month 12 patients experienced more than 24hrs delays in transfer.
  - There were no outliers as the total number of ventilated patients cared for outside ICU was none.
  - None of the patients had been ventilated on the unit for longer than 3 weeks and they did not have any patients in February with long term weaning problems.
- A service evaluation and improvement project was carried out on the provision of' Rehabilitation in Critical Care' in March 2015, against the compliance with NICE recommendations of CG83 (2009a) and The Faculty Of Intensive Care Medicine / The Intensive Care Society (2013). Core Standard 1.3.1 for Intensive Care Units (FICM 2013).
- Result of this study was based on a sample of 58 patients and looked at 13 areas and highlighted that 11 areas needed improvement. For example; none of the patients had a named healthcare professional identified, with the appropriate competencies, to coordinate their rehabilitation care pathway, percentage of patients who had a clinical assessment performed to determine their risk of developing physical and non-physical morbidity on discharge was not measured and there was no evidence that the ICU Steps leaflet "Intensive Care: A guide for patients and relatives" was provided to everyone during their stay on the unit. This leaflet contains information about the critical illness, interventions and treatments and recovery from critical illness.
- We asked for evidence of audits undertaken by the trust to monitor compliance with GPICS guidelines. They forwarded us the Therapy Review which took place in January 2016 with the recommendations from the review and an action plan with time scales.

Competent staff

- Information from the matron and the training records showed that 38% of nursing staff had post registration training in critical care nursing. Guidelines for the Provision of Intensive Care Services, 2015 recommends that a minimum of 50% of registered nursing staff should have a post registration award in critical care nursing in each unit. The matron informed us that they had commenced to put forward two nurses to complete post registration programme of study in critical care and this was to continue each year. They envisaged by 2018 they would achieve the 50% target. We spoke with one of the staff who had been seconded. They were enthusiastic about the opportunity.
- Staff told us the clinical educator was trying to facilitate all nurses to complete critical care competencies. Nurses who had completed their induction had commenced the 'Steps' competency programme. This is a national competency framework for adult critical care nurses and comprises of three steps which helps build skill, knowledge and confidence to becoming a competent critical care nurse. This has been developed to use alongside academic programmes of study.

Critical care

- Staff told us that they were happy to complete the work in their own time but they were finding it difficult arranging meetings with their supervisor to sign off the sections they had completed. Our observations confirmed that daily staff shortage did not allow nurses the time to make progress.
- We asked the matron and the Band 7 staff about the arrangements for supporting and managing staff competencies. We were informed that staff did not have any formal one-to-one meetings with their supervisors and this was done informally by the shift co-ordinators.
- Appraisals were completed yearly. Three staff we spoke with said that appraisals were just a paper exercise and they did not feel they were being listened to by their supervisors.
- The matron explained that clinical supervision was carried out on each day by the clinical educator and the care co-ordinator during each shift and they said work had commenced on nurses revalidation.
- On 16 March 2016, out of 46 staff employed, 25 (54.3%) staff had an appraisal in the last 12months. We spoke with eight staff, two staff could not remember when they last had an appraisal and three said it was well over 12 months and three staff said they had an appraisal in the last 12 months.
- Guidelines for the Provision of Intensive Care Services, 2015 recommends that each Critical Care Unit should have a dedicated clinical nurse educator responsible for coordinating the education, training and continuous professional development (CPD). There was a 0.5 whole time equivalent band 7 nurse allocated to be responsible for coordinating the education. Due to the on-going staff shortage the nurse was unable to spend time on education of staff. This highlights non-compliance with the guidelines.

- We noted new equipment on the unit and asked staff how they became familiar and competent in using them. They said that the clinical educator organised the training through the company representatives. The representatives visited the unit on several occasions to capture all staff and gave them training. Staff also assured us that the clinical educator did not allow any new equipment to be made available on the unit until all relevant staff had been trained. A staff attendance list was maintained by the clinical educator. The information provided by the trust for October to December 2015 showed that staff training compliance in high risk devices, medium risk devices and low risk devices were all 94%.That was out of 51 staff 48 attended the training.
- A new ventilator had been introduced onto the unit in January 2016.The company who manufactured the new ventilator had delivered additional training on the unit on 4 May 2016. Staff completed the company's documentation; this was not unit or trust specific or competency based.
- Staff completed an annual self-assessment of medical devices training. Staff kept their self-assessment documents. A central log of this was not held on the unit.
- There was no policy or process in place to review competencies; staff identified this as part of their appraisal and training and support was planned.
- New staff to critical care had a six week supernumerary period.

- Doctors we spoke with said they did not receive similar training. However if they were on the unit when training was offered they said that they would attend. Two middle grade doctors said that they relied on their colleagues or nursing staff to help them with unfamiliar equipment. They said that they would never try to operate machinery they were not trained on.
- Consultants told us that patients requiring tracheostomies had reduced and as a result, from performing approximately four operations a year, it had reduced to two. They said this caused problems with maintenance of their competency. Therefore the present arrangement was to refer patients to the ear nose and throat (ENT) consultants who were able to perform tracheostomies on a Friday.
- They did not have a standard operating policy for emergency tracheostomy.
- We raised our concerns about the nursing staff competency on caring for patients with tracheostomy with the matron and they told us that they had identified it as a potential risk and were looking at options such as seconding staff to other hospitals to gain experience and therefore confidence.
- We spoke with a clinical pharmacist who visited the unit. They said that they got involved in training nurses especially helping the advanced nurse prescribers.
- We were informed by a medical consultant that through simulation, they were developing staff skills and

competencies. They informed us that there were teaching sessions every Wednesday and the first Wednesday of the month was reserved for critical care topics such as immuno-nutrition, vitamin D, peripheral nutrition, COPD, sepsis and contrast induced nephropathy. They said continuous veno-venous haemofiltration (CVVH) training was planned for 6th April 2016.

- Medical staff told us when the unit was not busy, the teams worked in close collaboration with others in the anaesthetic department. There was strong support for appraisals and revalidation amongst anaesthetic colleagues.

Unannounced inspection 11 May 2016

- Following the incident in April 2016, we requested an action plan to prevent recurrence. The trust recognised the need to develop a training framework which included a sustainable plan to ensure ongoing critical care training and education for new and existing staff.
- Two weeks prior to our unannounced focussed inspection the clinical educator had updated the medical devices training form and started to collect a central log of the self-assessment.
- The clinical educator had also relaunched the national critical care nursing competencies (STEPS) on to the unit. Each Band 6 was allocated two Band 5's to support them through their competencies. The unit did not have a central log of staff progress with competencies.

Multidisciplinary working

- Patients' care and treatment was planned and delivered by a multidisciplinary team of staff which included doctors, nurses, physiotherapists, nutritionists and pharmacists. We were informed that they did not have a psychiatrist's service for critical care patients. The lead anaesthetist told us that if there was a need they would seek the input from a psychiatrist.
- One of the recommendations by the Guidelines for the Provision of Intensive Care Services, 2015 is that Care must be led by a consultant in Intensive Care Medicine. Consultant intensivist should lead the multi-disciplinary clinical ward rounds within Intensive Care and this should occur every day, including weekends and national holidays. The ward round must have daily input from nursing, microbiology, pharmacy and physiotherapy.
- We attended the handover sessions and ward rounds. Our findings confirmed that multi-disciplinary clinical ward rounds within critical care did not happen. This was also confirmed by the doctors and the AHPs we spoke with.
- The present arrangement included at the beginning of each shift nurses handing over between them. The handover between the doctors happened in theatre recovery away from the unit. Handover discussions of the critical care patients by the middle grade covering the previous night to the Consultant and middle grade in charge for critical care for the day. It was a general brief about the overall anaesthetic plan for the day across the theatres, obstetrics and intensive care. Following this, the consultant carried out a board round when they discussed the patients on the unit at the patient name board away from the individual patients. Patients' notes were updated during this. Allied Health Professionals (AHP) visited the unit at different times of the day and attended to the patients. They read the medical notes to see if there were any changes and added their comments. This meant unless there was a complex case review, the multi-professional team did not get an opportunity to meet and discuss patients on the unit. Therefore the present arrangement fell short of the Provision of Intensive Care Services Guidelines 2015.
- We saw the reasons for admission to the critical care were clearly recorded in patient's medical notes so that the information was available for the multidisciplinary team.
- Once a patient was ready to leave critical care the relevant parent (medical or surgical) team was contacted or if the patient was cared for under the Shared care model the parent team was already involved in the decision. We observed a good multidisciplinary approach to patient transfer on to the wards, where each discipline had a telephone conversation with the relevant ward staff which was followed by a transfer form with necessary information about the patient shared with ward staff.
- The nurse led ACT was also informed and the transfer information was shared to promote a smooth transfer.
- We were informed by the consultants that patients received sufficient rehabilitation from the physiotherapist on the wards but when patients were discharged from the hospital they did not provide any

rehabilitation or support services; however all patients were given information on how to contact The West Yorkshire Adult Critical Care Operational Delivery Network where patients were able to access services.
- We observed patients being transferred to other hospitals since they had Service Level Agreements to carry out certain procedures. This was carried out in an effective way so that patients and relatives were kept up to date with progress and the arrangements by the different professionals and the transfers took place with minimum disruption. One patient and two relatives said that they knew the reason for the transfer and that they were happy with the arrangements.
- A nurse was employed part time to work with an audit clerk to collect and submit data for different sectors which also included patient safety thermometer.

Seven-day services

- Seven day services are intended to ensure all patients receive a consistent, high quality urgent and emergency care service across the seven days of the week. ITU was a seven days service. There were medical, nursing and AHP available over seven days. We verified this by looking at staff rota, patients' notes and talking to patients and staff.
- There was Monday to Friday, 9am to 5pm, cover from the pharmacist, microbiologist, physiotherapist and nutritionist. At the weekends, national holidays and evening's patients had on call cover from physiotherapist and pharmacist.
- There was access to radiography and radiology seven days a week.
- Hospital inpatients had 24 hour access, seven days a week, to a consultant.

Access to information

- Patients' notes included risk assessments, care plans, case notes and test results.
- Information needed to deliver effective care and treatment was available to staff in electronic and paper based systems.
- Staff told us that through the electronic record system they were able to access information in a timely manner. Medical staff and members of ACT said that they were able to keep up-to-date with information of patients even when they were unable to get to the unit in person.
- When patients were transferred to the wards or to different hospitals, the information belonging to the patients was transferred in line with Data Protection Act 1998 and the Code of practice on confidential personal information to ensure patient confidentiality was maintained
- There was a formal handover document for transfer of patients from the CCU. This complied with NICE CG50. NICE CG50 refers to the 'Acutely ill adults in hospital; recognising and responding to deterioration'. The information helps the ward staff and the ACT to compare the patients' conditions prior to transfer and help assess any changes to the patient's condition following transfer.

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

- We spoke with five staff about consent and decision making requirements, including the Mental Capacity Act 2005. They had a good understanding of how they applied the Mental Capacity Act to their patients, how valid consent was sought and who should be involved. Medical staff said they had training in the topics during their foundation training and also covered aspects of gaining consent during their induction. Four nurses said that they had training on the topics as part of their mandatory training. We observed staff explaining and gaining consent from patients when they carried out personal care. Patients were given time to understand what was said. Staff did not rush patients and gave them plenty of time and tried different ways of explaining. A patient said a doctor drew a diagram when he was explaining about his condition and what had happened to him. They said that it made a big difference to them and they understood fully.
- One patient and three relatives told us that doctors explained the treatment with them and gave them the choices. They were given the opportunity to ask questions before agreeing to treatment. One family member said that the doctors did what was best for their relative and at the first opportunity they were contacted and given explanation as to why the person was on the specific treatment as the doctors had to make a 'quick decision'. They were pleased by the way patients and relatives were involved in the decisions. We noted documentation in patients' notes when they had been consulted and agreement reached for procedures.
- We talked with patients, relatives and staff about written and verbal consent. Patients and relatives understood the need for consent to treatment. They were happy

with the present arrangements. Staff verbalised the need for written consent and highlighted when this was not possible and explained how they reached the best interest decisions.
- The trust's Deprivation of Liberty Safeguards (DoLS) policy and the implications for the Critical Care Unit was under review at the time of inspection.
- There was a sedation policy which needed review. Review had taken place and they were awaiting ratification. Staff involved with managing sedation had been informed of the new updated sedation policy by a consultant.

Are critical care services caring?

Good

We rated the service as good for caring because:

- Patients experienced positive interaction with staff. When attending to patients healthcare professionals explained who they were and what they were there to do.
- Staff were mindful of patients' preferences especially who they want to share the information about their condition with and their decision for the treatment.
- Patients were given options and allowed to make decisions according to their preferences. Patients were supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
- 'Patient diaries' were used to assist patients reflect retrospectively on their experience of the critical illness. The diaries help patients fill in the gaps in their memory and make sense of what happened to them.

Compassionate care

- We spoke with five patients including patients who had been transferred to the wards. We considered comments from six relatives. We observed and spoke with five staff during our inspection.
- Patients experienced positive interactions with staff. When healthcare professionals attended to patients, they explained who they were and what they were there to do. Staff were mindful of patients' preferences especially who they want to share the information about their condition with and their decision for the treatment. These observations endorsed that staff complied with NICE quality standard [QS15] Patient experience in adult NHS services.
- Patients said that staff were very busy, but when they attended to their personal care they made time to talk to them and showed respect and consideration. They told us that staff provided privacy and maintained their dignity at all times. They also said that they were confident that information about them was treated with discretion and only shared with people who needed to be informed.
- We observed notices attached to curtains when patients were given physical or intimate care requesting visitors not to enter the bed area.
- We observed staff respecting patients' confidentially at all times for example when discussing results of tests and during handing over care.
- We saw staff being sensitive and supportive to patients and relatives. On one occasion we observed an AHP was given sensitive personal information by a relative and this was handled with care and respect by the AHP ensuring the information was only passed on to the appropriate person.
- Patients and relatives were able to access religious representatives through the hospital chaplaincy service to support them with emotional and faith needs.
- Critical care units were open plan, mixed sex units which remained a problem to maintain privacy and dignity of patients. However, staff used appropriate screening between beds to maintain patients' privacy.

Understanding and involvement of patients and those close to them

- Five relatives confirmed that they were fully informed by the medical and nursing staff of the care and treatment of their family member and they were satisfied.
- Four patients commented that they were happy with the way explanation was given to them by staff. They said staff explained in a way they could understand
- Two patients and three relatives told us, when staff explained about the treatment options they gave them sufficient time to understand and they felt involved in all the decisions.
- Family members told us that staff kept them updated with the progress of the patients and we noted that discussions were recorded in patients' notes.

- Staff said that from the time of admission and throughout the patients' stay on the unit they sought information from the family members about the patients' preferences of care and treatment. This helped families to feel that they were included and patients' wishes were respected.
- Nurses and doctors told us that information to patients was communicated in a way that was tailored to individual patient's needs. They said that on some occasions they had used diagrams and pictures to explain complex information.
- Our findings confirmed that patients were supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences. Patients were given options and allowed to make decisions according to their preferences. This meant staff were compliant with NICE quality standard [QS15} statements such as Understanding treatment options, Shared decision making and Supporting patient choice.
- Staff informed us that they had access to language interpreters, sign language interpreters, specialist advisors or advocates. Staff told us that during our inspection the in-patients on the unit did not require any.
- There was a staff member who was responsible for approaching relatives for organ donations when treatment was being withdrawn. The contact details were available to staff on the unit and staff knew the criteria for the referral.

Emotional support

- Staff were fully aware of the impact on patients' wellbeing following admission to CCU. They told us that as part of the induction to the unit they had received training and that they provided emotional support to patients and their family members.
- 'Patient diaries' were used to assist patients reflect retrospectively on their journey/experience of the critical illness.
- The diaries were written by family members and staff to help the patient find out what had happened when they were critically ill. Some patients experience post-traumatic stress disorder when they have been a patient on the unit. The diaries help patients fill in the gaps in their memory and make sense of what happened. Families of patients who were on the unit told us how the information within the diary would help them remember what happened and enable the patient 'make sense of it all'.
- Doctors and nurses told us that they had training on breaking bad news when patients' condition worsened. They said that such meetings were led by a senior doctor and joined by the nurse looking after the patient at that time. Medical staff told us that they discussed the information with their team members and agreed on the way information should be delivered. They said that this was carried out in a calm and sensitive manner.
- There was a chaplaincy service. Staff told us that they were able to access representatives from the local religious denominations.
- We were informed when patients moved on to wards they were attended to by the acute care team (ACT) who provided support to ward staff and enabled patients recovery and discharge. We observed that the ACT supported patients clinically. They said if patients were identified as requiring emotional support, they would contact the counselling services.

Are critical care services responsive?

Requires improvement

We rated the service as requiring improvement for responsiveness because:

- Patients well enough to leave the unit experienced delays being transferred to a ward more conducive to their recovery. Twelve patients in one month experienced delays of more than 24 hours, also potentially reducing the unit's ability to admit patients in need of critical care
- Patients did not have any formal follow-up arrangements when they were discharged into the community. Those who required rehabilitation and/or emotional support following treatment in critical care were expected to source their own services.

However, we also found:

- Patients needing specialist procedures were treated by the critical care unit in conjunction with the regional centres so that local patients' needs were met.

- Criteria for the admission to the unit ensured patients were not discriminated against due to their age, gender or ethnicity.
- Staff took account of each patient's personal circumstances, preferences and coexisting conditions when planning and delivering care.

Are critical care services well-led?

Requires improvement

We rated the service as requires improvement for well-led because:

- There was no local strategy for the critical care unit.
- There was a lack of evidence that the governance framework and management systems had been embedded to ensure staff were familiar with the reviews and improvements to the service.
- There was a lack of learning from some incidents. Significant issues that threatened the delivery of safe and effective care were not always identified promptly and adequate action taken to manage them.
- There was insufficient assurance that risks were being adequately identified and managed.
- Staff satisfaction survey outcomes were not shared with staff although staff took part in it each year.
- The systems in place did not promote sharing of information between the trust level staff and the front line clinical staff within the unit creating a gap in the flow of information.
- Safety procedures had not been reviewed and audited to ensure they were safe. Senior staff were unaware of national guidance and did not ensure compliance with the NHS England guidance on nurse staffing.
- The NICE report published in 2013 showed that there were improvements to be made in training, management of beds and the management of risk on the unit. Two years following the report, no evidence was available to show that action had been taken to make improvements.

Vision and strategy for this service

- There was no local strategy for the critical care unit. We asked staff and the matron whether they had developed their own vision and strategy for the critical care unit based on the trust information. Staff told us that due to pressures at work they were focused on delivering good quality care to patients and had not given much thought to looking at the vision and developing strategies. Matron supported the comments by staff.
- Information about the vision, priorities and values of the trust displayed on notice boards around the hospital an on the computer screens on the unit.
- Staff members told us that they fully agreed with the first principle which was that they were 'Here to Care' and that it underpinned their priorities and values.
- They said that they understood their roles and responsibilities and strived to deliver the best quality care they could.

Governance, risk management and quality measurement

- A governance framework had been introduced by the trust to support the delivery of the trust strategy and good quality of care.
- During our inspection we found that the systems in place did not promote sharing of information between the trust level staff and the front line workers within the hospital. We spoke with staff, read minutes of meetings and viewed update letters from trust management. We confirmed that trust level information was cascaded down to band 8 (matron) and equivalent staff who held middle management posts. However, minutes of meetings regarding the unit were not shared with all staff.
- There was lack of evidence that the governance framework and management systems had been embedded and whether staff were familiar with the processes of reviews and improvements to the service. Staff could not articulate the systems in place.
- The matron told us they had monthly meetings with band 7 staff and the ACT where they shared information. The meetings were not always recorded and therefore we did not see the minutes of the last meeting.
- We asked to see the programme of clinical and internal audits, which was used to monitor quality of service and the action plans addressing improvement. The trust was unable to provide us with this information during our inspection. They told us that they had not formalised the audits and accepted that this was a gap in the service; they insisted that they carried out informal audits and spot checks regularly.
- The matron said a monthly update to the risk register was produced at each Clinical Business Unit (CBU)

meeting. We saw the minutes of the meeting where staffing was identified as an ongoing risk. The risks were discussed and actions had been agreed. For example, they told us that they had tried different measures to recruit and train nursing staff. However, the risks we identified at the inspections were not all on the CBU risk register; this included nurse staffing.

- The CCG undertook a walk-around of the services provided by the trust in 2015. An area for improvement relevant to the critical care unit was staffing issues.
- The matron and the clinical educator were aware of the Guidelines for the Provision of Intensive Care Services (2015). They told us that they were aware of areas they were not fully compliant.
- National Safety Standards for Invasive Procedures (NatSSIPs) Version number 1 was published on 7 September 2015. It set out specific responsibilities for those providing NHS funded care in respect of members of a trust board, Medical Director, Chief Nurse, local governance and safety lead. It is expected where invasive procedures were performed, there should be local standards that were compliant with the national standards. To ensure local compliance, audits should be conducted regularly and the results of the audit are reported to the Board and acted upon as appropriate. A member of the senior staff was not aware of NatSSIPs. They did not know whether audits had been carried out by the chief nurse or the local governance and safety lead.
- There was a named individual who was responsible for monitoring compliance with NICE guidance on the unit. The last report which was in 2013, on the compliance of NICE guidance CG50 (Acutely ill adults in hospital: recognising and responding to deterioration) indicated that handover sheets needed to be developed and used for level 3 patients. During our inspection we did not see staff using a standardised handover sheet. The nurses used a form and the medical staff made their notes on paper.
- The action plan from the report in 2013 also highlighted continued training programme for clinical staff on vital signs monitoring and escalation, medical management of Level 2 and 3 critical care beds needs to be more structured and risk assessment to be re-reviewed and progress monitored by Governance Group. Senior staff were unable to supply us evidence of the progress made in the above areas in the last two years.
- We were informed that NEWS audits were not carried out to monitor appropriateness of the admissions to the unit and whether the escalation carried out in a timely manner to ensure that patients received treatment without delay.
- The critical care team carried out an operational policy review in October 2015, to establish the criteria as to who should be contacted first in emergencies, whether the anaesthetists or the parent team. This remained 'amber' in the risk register as solutions had not been fully implemented.

Unannounced inspection

- Following our inspection in March 2016, the Trust informed us of a serious incident that had occurred on the critical care unit. The trust provided information on their initial actions following the incident which included a two person check on the ventilator equipment. On further analysis of this and other evidence, we undertook a further unannounced focussed inspection.
- We found that no monitoring had been undertaken to provide assurance to the trust that the checks were undertaken as planned. A Director was asked to provide assurance and audits regarding the equipment checks. We were not provided with sufficient assurance that action or actions to mitigate the risks had been undertaken following the serious incident.
- We found there was no dedicated ward manager for the unit, the matron cover was provided by the surgical division matron and the service did not have a robust way of checking and recording staff skills, knowledge and competence.
- We had concerns regarding telemetry monitoring as we found there was no dedicated member of staff to oversee monitoring of patients. In addition, there was no set process for the frequency of monitoring and recording checks for staff to follow.
- Following the unannounced inspection we met with the Chief Executive to raise concerns regarding staffing, staff skills and competence, telemetry and senior clinical oversight of the unit. The trust developed an action plan to address the areas of concerns.

Leadership of service

- There was a structure within the unit for doctors, nurses and the multidisciplinary staff. We noted that patients received consistent care as staff demonstrated their responsibilities. This confirmed that the team had the capability and experience to offer their service.
- We met with the critical care leadership team. It consisted of a consultant anaesthetist who was the Clinical Director for anaesthetics, a consultant anaesthetist who was a clinical lead for critical care and was involved in the shared care model, matron for surgical services, the matron for critical care and two business managers. They informed us that following the last CQC inspection they had made the unit safer by staff using swipe cards. They spoke to us about the challenges they faced and how they were managing them.
- They said due to the availability of consultants, each day a different consultant provided cover for 24hours, instead of consultants providing cover over blocks of shifts such as four day and night cover which would promote continuity. To address this they were using a shared care model, where parent consultants managed the care of the patients on the CCU.
- Staff told us that they had seen management 'walk rounds' and discussions with the matron or the person in charge of the unit. They said that they could approach them if they wanted to.
- However, frontline clinical staff commented that they have 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 .
- Staff made comments that their managers were under pressure and that their 'hands were tied'.
- The multidisciplinary staff informed us that they had a good relationship amongst them and that they appreciated each other's contribution and supported them.
- We found the leadership of the CCU did not ensure compliance with the NHS England 2014/D9/S/a guidance.

Unannounced inspection

- Following the unannounced inspection the trust appointed a band 7 to provide ward leadership and a dedicated matron to provide clinical leadership to the unit.

Culture within the service

- Staff said the manager listened to them and was approachable. However they found the manager did not respond to their requests promptly and in a timely manner. They gave an example about the lack of progress in providing safe staffing levels.
- Some staff expressed high levels of stress and work overload.
- Staff members said that they felt valued by their colleagues.
- Matron told us when they found problems with staff behaviour or performance they addressed them with the help of their human resource team.
- All multidisciplinary staff we came into contact with demonstrated their commitment to the needs and experience of the patients/people.
- We observed staff teams working collaboratively and sharing responsibilities to deliver good quality care.

Public engagement

- We saw evidence that people attending CCU had access to 'Friends and Family Test' (FFT) surveys. In February 2016 there had been 100% response from those who completed the test. The results were positive and these were displayed on the unit.
- Due to the short stay on the unit, patients and their representatives did not get the opportunity to be engaged and involved in the decisions about the unit.

Staff engagement

- Band 5, band 6 and other front line staff were not invited to monthly meetings. They told us that they were given information by band 7 staff on a need to know basis.
- Staff told us that they had staff satisfaction surveys, which they had responded to but did not find out the findings.
- They said that they had an open invitation to the trust board meetings, which they did not have the opportunity to attend. This was due to shortage of staff and management not facilitating staff to attend such meeting

- They did not have multidisciplinary staff meetings where staff would share information, engage in developmental activities and maintain networking with different professional.

Innovation, improvement and sustainability

- Physiotherapists have introduced special exercise wheels to bedbound patients on the unit to promote muscle strength and encourage exercise activities whist in bed.

Maternity and gynaecology

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

Information about the service

Airedale NHS Foundation Trust offered a range of maternity services for women and families within the hospital and community setting across West and North Yorkshire, and East Lancashire. Services ranged from specialist care for women with increased risks to a home-birth service and midwifery led care for low risk pregnancies.

The labour ward had eight delivery rooms; four of these were low risk midwife-led rooms and had active birth equipment and two had birthing pools. There were four consultant led rooms used for higher risk pregnancies and births. The labour ward also had four induction beds. There was direct access to an obstetric theatre from the labour ward.

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

The maternity assessment centre was available for women over 20 weeks pregnant. Antenatal clinics were run at the hospital and had two ultrasound scanning rooms. Antenatal and postnatal care was provided on Ward 21 which had 15 beds.

Gynaecology inpatient services were provided on ward 13 which had 30 beds and also admitted general surgery patients. An early pregnancy unit was available for women under 20 weeks pregnant.

The maternity services at Airedale NHS Foundation Trust delivered 2,158 babies between July 2014 and June 2015.

The trust did a limited number of surgical terminations of pregnancies. Between September 2015 and March 2016, one had been performed. Medical terminations of pregnancy were not provided by the service.

During our inspection we visited the antenatal and postnatal ward (ward 21), labour ward, maternity assessment unit, early pregnancy unit, antenatal clinics and ward 13. We spoke with nine women, three partners and 36 staff including senior managers, and service leads, ward managers, midwives, consultants, doctors, nurses, anaesthetists, health care support workers, administrators and domestics. We reviewed 18 sets of maternity records.

Maternity and gynaecology

Summary of findings

Overall we rated maternity and gynaecology services as good. We rated caring, effective, responsive and well-led as good. We rated safe as requires improvement.

The trust monitored and recorded patient outcomes on a monthly performance dashboard. Outcomes for patients that used the service were in line with national averages.

People were supported, treated with dignity and respect, and were involved in making decisions about their care. People spoke positively about the staff and felt supported and cared for.

Women's individual needs were taken into account in planning the level of support throughout their pregnancy. The service took account of complaints and concerns and implemented action to improve the quality of care.

We found effective governance arrangements were embedded and enabled the monitoring of risk. Performance and outcome data was monitored and reported monthly. Staff were encouraged to raise concerns and told us leaders were visible and accessible.

However:

We lacked assurance around the consistency of checking of emergency equipment for adult and new born babies. For example, the neonatal resuscitaire on labour ward had a period of eight consecutive days with no recorded checks. The temperatures of refrigerators used for storing medication were not consistently monitored. Records showed that when temperatures were out of the recommended range for some of the refrigerators no action had been taken. Root cause analyses were not always completed in a timely manner. Mandatory training figures for the service was below the trust target of 80%.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Investigations into incidents were not always timely. We saw evidence of one outstanding root-cause analysis (RCA) from 2014, resulting in a delay in recommendations to prevent safety incidents reoccurring.
- Checking of emergency resuscitation equipment for adults and babies was not robust. We found large gaps in daily checking in all of the clinical areas we visited. For example, the neonatal resuscitaire on labour ward had a period of eight consecutive days with no recorded checks.
- We found gaps in daily checking of fridge temperatures and no action taken when temperatures went out of range.
- Mandatory training figures and safeguarding level 3 figures for maternity staff were below the trust target of 80%.

However, we found:

- There were clear safeguarding processes in place and staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- Records relating to women's care were detailed and identified individual needs.

Incidents

- The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust electronic reporting system. The staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.
- Between February 2015 and January 2016 there were 532 incidents reported across maternity and gynaecology services; one incident was classified as 'severe harm', 23 moderate harm, 132 low harm and 376

were classified as no harm. Themes of incidents included: complication from treatment, for example 3rd degree tears, post-partum haemorrhages (PPH) and term babies transferred to the neonatal unit.

- There were no never events reported between February 2015 and January 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Between February 2015 and January 2016 maternity and gynaecology services reported three serious incidents to the NHS strategic executive information system (STEIS). These were incidents described as most serious and the trust completed a root cause analysis (RCA). A root cause analysis is a structured method used to analysis serious incidents. We reviewed one RCA and found actions plans were in place and recommendations made to prevent a reoccurrence. Following the serious incident, duty of candour was applied. The service had amended the checklist used following deliveries and now required the signature of two practitioners. We reviewed the checklist in two sets of records and found the checklist only had one signature, indicating the changes had yet to be fully embedded.
- We had concerns about the length of time it took to complete RCA's. We saw evidence of an RCA that was outstanding from August 2014. Of the three RCA's we reviewed, they took on average 126 working days to complete resulting in a delay in recommendations to prevent a safety incident reoccurring. Guidance from NHS England (2015) states that serious incidents investigated internally must be completed in 60 working days of the incident being reported. Staff told us it was challenging to complete RCA's in a timely manner due to clinical commitments.
- Senior staff reviewed incident forms daily and categorised them depending on the level of harm.
- Senior staff held weekly case review meetings on the labour ward to discuss any incidents including emergency caesarean sections, instrumental deliveries, shoulder dystocia (difficulty in delivering the baby's shoulders) and PPH above 1000mls. Staff said the reviews were a learning opportunity to see if changes to practice could be made and if the incident required a RCA or any immediate actions.
- Senior staff told us feedback from incidents and learning was shared in a number of ways including; monthly ward meetings, face to face feedback, use of a communication folder on the labour ward, publication of a monthly risk bulletin, and emails. Maternity services were planning on introducing YAMMER, a private social network that would allow staff to share confidential information and promote learning from incidents. We were not assured that all incidents were disseminated amongst staff at ward level. Three midwives were not aware of the recent SI in maternity.
- We saw evidence of monthly multidisciplinary perinatal mortality and morbidity meetings. Staff discussed individual clinical cases and recommendations were made to improve care and treatment.
- Staff spoke about duty of candour and understood the importance of being open and honest with patients. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were able to give examples of when the duty of candour had been applied following a delay in treatment. Staff explained following any serious incidents, patients received a duty of candour letter offering an apology and were invited to attend a meeting to discuss the outcome of the investigation.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- Safety thermometer data was displayed on ward 13. In March 2016, up until the time of our inspection, there were no recorded incidents relating to falls, medication errors, pressure ulcers, Methicillin-Resistant Staphylococcus aureus (MRSA) or Clostridium difficile.
- The maternity safety thermometer allows maternity teams to monitor and record the proportion of mothers

who have experienced harm free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a check used by midwives and doctors to assess the health of a new-born) of less than seven at five minutes and those who are admitted to a neonatal unit. The labour ward did not submit or display any data to the maternity safety thermometer. However, we did see information displayed about key performance indicators including; the number of 3rd degree tears, the number of caesarean sections and the number of women to midwife ratio.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired MRSA or Clostridium difficile reported between March 2015 and November 2015 within maternity and gynaecology services.
- The trust completed monthly hand hygiene audits. On average between November 2014 and November 2015 ward 21 was 97% compliant, ward 13 was 96% compliant and labour ward was 97% compliant with hand hygiene.
- Monthly infection control audits were undertaken. Data from October 2015 showed good compliance with central and peripheral venous catheter hygiene (a small, flexible tube placed into a vein to administer medication or fluids) and urinary catheter care.
- The trust completed environmental audits looking at the cleanliness of ward areas including sluices, bedded areas, corridors and clinical rooms. All areas within maternity scored above 95%, with the exception of the labour ward which scored 90%. The audit identified dust on radiator grills and bed lights and damage to wall plaster.
- Women were screened for MRSA before undergoing elective caesarean sections as part of the pre-operative assessment.
- We observed staff using personal protective equipment when required, and they adhered to 'bare below the elbow' guidance. Women we spoke to said they had observed all disciplines of staff washing their hands and using hand gel.
- Staff followed best practice with infection control and prevention principles in relation to management of clinical waste.
- Infection prevention and control training was part of the trusts mandatory training. Training records showed 78% of staff had competed infection prevention control training against the trust target of 80%.
- All areas we visited appeared visibly clean, staff cleaned equipment after use and used 'I am clean' stickers to indicate it was clean and ready for use. However, we found four commodes in the sluice on ward 13 that were visibly clean but did not have an 'I am clean' sticker.
- Cleaning rotas were displayed in all delivery rooms on the labour ward and had been completed.
- There were antibacterial gel dispensers on entry to all clinical areas we visited. Ward 21 had a four-bedded bay and we noted that each bed did not have an antibacterial gel dispenser. World Health Organisation (WHO) guidelines on hand hygiene in health care (2009) state that alcohol-based hand rubs should be readily accessible at the point of care.
- The labour ward had a designated domestic until 13:00, after this time the healthcare assistant and the midwives were responsible for cleaning the delivery rooms. Staff said, at times of increased activity they were taken away from clinical duties to assist in cleaning in order to prepare delivery rooms for expectant mums.
- Women were offered the influenza vaccinations at their antenatal appointment.

Environment and equipment

- We were not assured that robust systems were in place for checking emergency equipment. The Royal College of Anaesthetics recommend that resuscitation trolleys are checked daily. We checked the adult resuscitation trolleys on all wards we visited and found gaps in daily checking on every ward. On the labour ward there were 19 days in February and 10 days in March when checks had not been completed, and on ward 13 there were four days in February and 10 days in January when checks had not been completed.
- On labour ward and ward 21 the documentation for checking of the neonatal resuscitaires was not robust. We found gaps of up to eight consecutive days on the labour ward and on ward 21 the neonatal resuscitaire was not checked from the 16 February to 1 March, and we saw further gaps from 12 January to 2 February 2016.

- All entrances to the labour ward and ward 21 were locked and admission was only possible via a telecom system. Staff gained entry via a swipe card system. Closed-circuit television (CCTV) cameras were installed at the entrances to the labour ward and ward 21.
- The labour ward had two reception desks; this enabled staff to monitor visitors entering and leaving the ward and complied with Health Building Note 09-02 – Maternity care facilities (2013).
- There was adequate equipment on the wards to ensure safe care; staff confirmed they had sufficient equipment to meet patients' needs. Cardiotocography (CTG) equipment was available to enable staff to monitor the foetal heart rate in labour.
- The labour ward had recently been refurbished and had eight delivery rooms all of which had en-suite facilities. Four rooms were consultant led and four were midwife led. The midwife led rooms all had active birth equipment and two had birthing pools.
- Both birthing pools had telemetry facilities to allow high risk women to use the birthing pool. Safety nets were stored in a cupboard on the corridor, away from the delivery room. This could result in a delay in transferring a woman out of the pool in an emergency situation.
- All delivery rooms had birthing balls. The weight capacity of the birthing ball was determined by the circumference of the ball which was indicated by the colour of the ball. Two of the balls were under inflated.
- The obstetric theatre was located just off the delivery suite and enabled easy access.
- We checked a range of patient equipment including; blood pressure machines, infusions pumps and cardiac monitors. All patient equipment we looked at had visible evidence of electrical testing indicating it had been routinely checked for safety and when it was next due for service.
- We checked the fridges on the labour ward and ward 13 where foetal remains were stored before been transported to the mortuary. Staff told us the temperature of the fridge should be recorded daily. Upon checking we found gaps in the daily checking of the fridge temperatures on labour ward and ward 13.
- The trust completed 'clean hospitals' audits. In January 2016; labour ward, ward 21 and ward 13 all scored above 95%. The trust did not provide patient led assessments of the care environment (PLACE) audits for maternity and gynaecology services.

Medicines

- Maternity and gynaecology services did not report any medication errors that resulted in serious harm on the trust's quality dashboard.
- We checked the storage and administration of controlled drugs in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. After administration, the stock balance was confirmed to be correct and the balance recorded.
- Medications that required refrigeration were stored appropriately in fridges. There was a method in place to record daily fridge temperatures. However, on the labour ward we found gaps in the daily checking of fridge temperatures and no action was taken when the fridge temperature went out of range. In February 2016, the temperature was only checked on 10 occasions, and on 9 and 10 February we saw evidence of the fridge temperature going out of range. On both occasions the temperature was reset and not checked again until the 15 February. We did not see evidence of this been reported. Staff said they would not always report when the fridge temperature went out of range. If stored at an incorrect temperature, the safety and efficacy of medication can be affected. We raised this with staff at the time of inspection and they told us they would ensure daily checks were completed.
- During the visit, we found some intravenous fluids stored in open room in an unlocked cupboard on the labour ward. This was escalated to the ward staff, and a request was put in for a key pad to be fitted on the door.
- Nitrous oxide (Entonox) for pain relief was piped into all birthing rooms.
- We checked drug administration records of 12 women and found these had been fully completed, patients were getting their medication promptly and any allergies were clearly recorded on the prescription chart.
- We saw antibiotics been prescribed as per trust guidelines in the prescription charts we reviewed.
- We observed nursing staff getting interrupted during medication rounds on ward 13 despite them wearing 'do not disturb' tabards; this could increase the incidence of drug errors.

Records

- Women carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GP's. Results from antenatal tests were documented in these records. Maternity hospital records were stored in a records room within the department to allow access.
- Risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.
- The 'fresh eyes' approach was used to review CTG's. Staff told us CTG's were reviewed by another midwife every two hours and every four hours by the shift coordinator and stickers were used to record the minimum data set. We reviewed 15 case notes and saw evidence of this being documented.
- Notes were stored securely on all the wards we visited in line with the trusts data protection policy.
- We saw evidence of staff completing venous thromboembolism (VTE) risk assessments and a recent audit showed between March 2015 and November 2015, 95% of women had a documented VTE risk assessment.
- We reviewed 18 sets of records; records were legible, dated and signed, but the named midwife leading the women's care was not documented in three sets of notes.
- The service submitted monthly record keeping audits into an electronic audit tool. The results were immediately available for the wards to download and provided assurance that standards were been met; or identified areas of poor compliance.

Safeguarding

- There were effective processes in place to safeguard women and babies. The service had a named safeguarding midwife who supported staff with the safeguarding process.
- Staff understood their responsibilities in safeguarding vulnerable people. All staff we spoke to could describe how to identify safeguarding concerns and how to make a referral to the safeguarding team.
- The labour ward had a flow chart on display to assist staff on what to do if they had safeguarding concerns.
- We saw evidence in patient's records of good safeguarding documentation with clear plans; this included involving police liaison officers in cases of domestic violence.
- Staff were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. Babies on the labour ward and ward 21 had electronic tags that triggered an alarm if a baby was removed from the ward.
- The trusts annual safeguarding report included an annual review of safeguarding activity within maternity services. Of the deliveries in 2014/15, staff raised 158 alerts, this equated to 7.2% of all deliveries. Examples of safeguarding alerts raised included domestic violence, lack of support and situations in which babies required adoption.
- The trust had an up to date safeguarding children and young people policy which had regard to the statutory guidance 'Working Together to Safeguard Children' (DH 2015). The policy contained information with regards to Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE), the process to follow for did not attend (DNA) patients and for a possible abduction.
- To promote midwifery staff awareness of safeguarding, the safeguarding midwife had implemented a link midwife role for both hospital and community teams.
- Training records showed 85% of staff on ward 13 had completed safeguarding adults training and maternity services were 89% compliant with safeguarding adults training. This was above the trust target of 80%.
- Training records showed that 80% of gynaecology staff had completed safeguarding children level 3. This was in line with the trust target. However, within maternity services 68% of staff had completed safeguarding children level 3 training. This was below the trust target of 80%.
- Senior staff clearly demonstrated the process to safeguard women with or at risk of female genital mutilation (FGM). Staff understood their responsibilities to report any cases to the Department of Health and adopted a multi-agency approach to safeguard infants at risk of FGM including referral to the health visitor and school nurse. The trust had recently implemented a flow chart to support staff in identifying those at risk of FGM and the management.
- The maternity mandatory training programme included FGM training as part of safeguarding level 3 training.

Mandatory training

- Trust mandatory training included infection and prevention control, moving and handling training, information governance and equality and diversity and

was coordinated by the training department. Overall compliance within maternity was 71%; this was below the trust target of 80%. Gynaecology specialist nurses were above 92% compliant with trust mandatory training.

- Staff told us they could access trust mandatory training either via an electronic learning system or could attend face to face training. Some staff said they had difficulty completing mandatory training during clinical time due to staffing levels.
- All staff had a learning passport to record mandatory training attendance. Mandatory training compliance was monitored and staff reported that they were notified when training was due to be renewed. There was an escalation process in place for staff that were not compliant with mandatory training.
- Midwifery, medical staff and healthcare assistants (HCA) attended a two-day mandatory training programme yearly. Training included CTG interpretation, neonatal resuscitation, infant feeding, record keeping, learning from risk and safeguarding level 3 training. Staff also ran emergency drills of clinical scenarios. Training records for 2015 showed 87.7% of staff attended mandatory training day one and 96.6% attended day 2.

Assessing and responding to patient risk

- The World Health Organisation (WHO) surgical safety checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. The trust devised and introduced a modified maternity WHO checklist.
- The trust completed an audit of the maternity WHO surgical checklist in August 2015. Results showed that 96.5% were fully completed and 3.5% were partially completed against a trust target of 100% completion.
- The trust monitored compliance with the WHO checklist through monthly clinical governance meetings and had incorporated it into theatre key performance indicators. The trust had implemented a 'naming and shaming' strategy to improve compliance with completion of the WHO checklist. Staff felt this was effective and a review of the key performance indicators showed an improvement in compliance.
- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- We reviewed 17 records and in seven sets we saw evidence of uncompleted MEOWS charts for patients who required frequent observations, for example following a caesarean section. We reviewed MEOWS audits and ward 21 had above 95% compliance from December 2015 to February 2016. Compliance with MEOWS charts had not been audited on the labour ward.
- Staff understood the process for escalating concerns if a patient was deteriorating, staff told us they would contact the acute care team out of hours. Consultant paediatricians were available if staff had concerns about a baby.
- Consultant obstetricians were available out of hours for emergency caesarean section and if a patient's condition gave rise for concern.
- Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors, this determined if an individual was high or low risk.
- Women could contact the labour ward out of hours or the maternity assessment centre for advice and reassurance. Maternity staff assessed women who attended the maternity assessment centre. Staff reported good medical support from the labour ward medical staff.
- There was a clear process in place for the transfer of women from midwife led care to consultant led care and for transfer from homebirth to hospital.
- Community midwives did not attend babies born before arrival at home. The service had a 'scoop and run' arrangement in place with the ambulance service. Staff said that paramedics had been invited to attend YMET training days to develop their competencies.
- The labour ward had a sepsis box, which was a quick grab box and contained everything needed in cases of suspected sepsis.
- We saw evidence of staff completing venous thromboembolism (VTE) risk assessments and a recent audit showed 95% of women had a documented VTE risk assessment between March 2015 and November 2015.

- Senior staff held weekly case review meetings to discuss emergency caesarean sections, instrumental births, shoulder dystonia and PPH above 1000mls. Staff said the reviews were a learning opportunity to see if any changes in practice could be made.

Midwifery staffing

- 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 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.
- 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. During our inspection, staff said the staffing establishment was last reviewed in 2010. Staff felt there had been an increase in the complexity of patients seen on the labour ward and this was not reflected in the current establishment. Band 7 specialist midwives were included in the establishment despite only having a one day a month commitment to clinical duties. Some band 7 specialist midwives told us they had not worked clinically for several weeks.
- Actual and planned staffing levels were displayed on the wards we visited and were correct at the time of our inspection.
- The labour ward planned to have seven midwives on a morning and six midwives on a late shift Monday to Thursday. On a Friday and weekends they planned to have six midwives on an early, late and night shift. One healthcare assistant was planned for each shift. We reviewed two weeks of staff rotas for the labour ward and found planned staffing levels had not been achieved on nine days out of the 14. In March 2016 we saw three late shifts that were short of one midwife and one healthcare assistant, resulting in five midwives on the labour ward and no healthcare assistant.
- Within the planned midwifery staffing levels on labour ward, one midwife was designated to be a 'scrub' midwife on each shift. The 'scrub' midwife went into theatre for any elective or emergency caesarean sections. RCOG standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) state midwives should not be undertaking the 'scrub' role and recommended that there should be a dedicated theatre team.
- NICE guidelines on safe midwifery staffing for maternity settings (2015) stated that all women are provided with supportive 1:1 care in labour. The trust target for women receiving 1:1 care in labour was 90%. We reviewed the trust quality dashboard. Between March 2015 and November 2015 the trust failed to meet this target on five occasions and in April 2015 the percentage of women who received 1:1 care fell to 77.8%. Information displayed on the labour ward at the time of our inspection showed the number of women receiving 1:1 care had increased to 92%. Following the inspection the trust provided information that they had validated the data and this showed 1:1 care was between 97% and 99%.
- Staff recognised there were challenges in achieving 1:1 care. Staff said the challenges were around the scrub midwife, and if there was an emergency caesarean section they would have to go in to theatre. We saw evidence documented in records of midwives going into theatre, and therefore interrupting the provision of 1:1 care to women in labour. Staff did not consistently complete an incident report when this occurred. We raised these concerns with senior staff who told us the 'scrub' midwife was allocated either to women in the induction suite or to women who had delivered and was waiting transfer to the postnatal ward. They did not feel the 'scrub' midwife was having an impact on the provision of 1:1 care in labour.
- The labour ward monitored midwifery staffing levels daily and a red flag system had been implemented to escalate staffing concerns. The service used bank staff, asked staff to work overtime, moved midwives from the maternity assessment centre and contacted the on call community midwife.
- The community midwifery team completed an audit of on calls over the past 10 months and found that between January 2015 and November 2015 community midwives spent 150 hours on the labour ward and in April 2015 they were called to support 15 times. This had not impacted on community services.

- The patient case load for community midwives was 1:101; this was above the recommended ratio of 1:96 by the Royal College of Midwifes.
- Staff on the labour ward recognised the challenge of having only one healthcare assistant on each shift. The healthcare assistants had numerous responsibilities as well as their clinical duties including supporting in theatre, moving patients between the labour ward and ward 21, and due to the lack of domestic cover after 1pm they had to clean and prepare the delivery rooms. Healthcare assistants felt this impacted on the time they had available to spend with patients.
- Staff on the labour ward reported staffing levels on a weekend were challenging due to the closure of the maternity assessment centre. Any telephone calls were diverted to the labour ward. No clerical support was available on a weekend therefore, as well as caring for women on the labour ward staff had to do telephone triage and review antenatal and postnatal women attending the ward. We requested data from the trust about the number of women triaged by the labour ward on a weekend; however, data was not provided from the trust.
- We reviewed the staffing rota for ward 21 from November 2015 to March 2016. All shifts had the correct number of planned midwives. However, we found that 36 shifts were short of a healthcare assistant, resulting in two midwives looking after 15 patients with no healthcare assistant.
- We reviewed two weeks of staffing rotas on ward 13 and found 12 days when staffing levels were not met, on four occasions the ward was short of one registered nurse and on 12 occasions the ward was short of one healthcare assistant.
- The trust did not provide staffing rotas for the labour ward.
- Ward managers told us they were not supernumerary and found it challenging to manage their non-clinical duties alongside their clinical role.
- Gynaecology services had a 7% vacancy rate; information provided by the trust showed no staffing vacancies in maternity services.
- Sickness levels for the directorate in November 2015 were 2.6%. The target for the trust was 3.6%.
- We observed a morning handover on the labour ward. The handover was detailed and concise; midwives used the SBAR tool (situation, background, assessment, recommendation) to document details from the handover. Staffing and patient allocation was discussed however; the handover did not include any safety communication regarding issues which needed wider dissemination, for example, learning from incidents.
- The handover on ward 21 was recorded and was detailed and concise. Risk factors were highlighted and safeguarding concerns raised. Staff did not use the SBAR tool and there was no safety briefing included in the handover.

Medical staffing

- The labour ward had consultant cover 40 hours per week between March 2015 and November 2015. This was in line with the RCOG recommendations for the number of births. There was a consultant on call out of hours.
- The medical staffing mix for maternity and gynaecology services were in line with the England average, with 35% consultant grade compared to the England average 35%. Middle grade staff (that is doctors with at least three years as a senior house officer or at a higher grade) was 23%, above the England average of 8%. The trust had lower than the England average for registrar level staff, which formed 37% of staff, against an England average of 50%. Junior doctors, (those in foundation years one or two) made up 5% of staff, compared to the England average of 7%.
- A consultant anaesthetist was allocated to the labour ward Monday to Friday; an additional anaesthetist was available when the ward ran a list of elective caesarean sections. Out of hours an anaesthetist was available 24 hours a day, seven days a week.
- Staff in all areas said they could always speak to a doctor if advice was needed and if the situation required the doctor would attend the ward.
- Obstetrics and gynaecology locum use between July 2014 and March 2015 ranged from 19% to 6% with a peak in September 2014. We spoke to one locum who said they had been received a comprehensive induction and felt well supported.
- The vacancy rate for non-consultant grades, for example junior doctors was 11.5%. The service had over recruited at consultant level. This brought the overall medical staffing vacancies to 0%.
- Feedback from the General Medical Council National teaching survey raised concerns about obstetricians and

gynaecologists been expected to coordinate the care of patients on the intensive call unit. Staff told us this had now been resolved and the individual roles had been clarified.
- Consultant and gynaecology nurse specialist carried out daily ward rounds on ward 13.
- We observed the medical handover on labour ward and ward 13. A handover was given on all women including high risk women who were due to come into the labour ward. Planned inductions were discusses and any safeguarding concerns were raised. We saw good use of the SBAR tool on ward 13.

Major incident awareness and training

- Escalation policies for maternity services were in place and there was a clear process to implement plans during times of shortfalls in staffing levels and potential closure of the labour ward.
- The trust had a major incident policy that identified the roles and responsibilities of staff in different clinical areas. Staff was aware of the policy but not all were clear on their role.
- Medical staff and midwives attended yearly skills and drills training in neonatal and obstetric emergencies, these enabled staff to maintain skills in a range of emergency situations, for example maternal collapse, neonatal resuscitation and haemorrhage.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- Patient outcomes were monitored via the maternity dashboard. Outcomes for patients that used the service were in line with national averages when compared to similar services.
- 91% of staff within maternity and gynaecology services had completed an appraisal.
- We saw evidence of effective multidisciplinary team working which was coordinated.
- Women reported having their pain effectively managed and there were different options for managing pain. An anaesthetist was on duty to administer epidurals. Support was offered to women feeding babies.

However:

- Guidelines and policies were out of date and did not always reflect the most up to date practice.

Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines.
- Staff reported they could access guidance, policies and procedures on the trusts intranet website.
- We reviewed the available guidelines for maternity and gynaecology services and found 22 were out of date. Guidelines that had expired included: neonatal resuscitation, foetal monitoring and risk assessment in labour. The local risk register identified that a number of guidelines were out of date. Staff explained that the ratification process was lengthy and took up to 3 months; they told us guidelines had been allocated to physicians and were in the process of being updated.
- The service declared itself non-compliant with NICE guidance CG190 (2014) that recommend the use of oxytocin for preventing PPH. The trust used oxytocin and ergometrine which was against NICE guidance. This was identified on the risk register and a risk assessment was in place to mitigate against the risk.
- Guidelines for the management of diabetes expired in November 2015 and were based on NICE guidance from 2008 despite new guidance released in April 2015.
- We reviewed the clinical audit plan for 2014/15; women's services did not participate in any national audits. Eight audits had been completed in 2015, none of which consultant led or audits against NICE guidelines.
- The trust had implemented SaBiNE care bundles (focusing on reducing the number of stillbirths) and used customised growth charts to monitor babies' growth during pregnancy to reduce the rate of stillbirth.
- The trust complete monthly audits of nursing key performance indicators (which are agreed standards of good nursing care); they were tailored to suit each individual area. Submissions were made monthly via an electronic audit tool and the results were made available immediately to provide assurances to wards or identify any areas of poor compliance. Auditable

standards within maternity and gynaecology included record keeping, communication, post op observations, MEOW's, prescription charts, IV/SC infusions, infection, pressure ulcer assessments and safeguarding.

Pain relief

- Women received information of the pain relief options available to them, this included, nitrous oxide and oxygen (Entonox®) piped directly into all delivery rooms, access to one of two birthing pools and epidurals.
- Women in the induction suite were provided with written information about the different types of pain relief. This information was available in different languages.
- Midwives were trained in and offered antenatal hypnobirthing training programmes for expectant mums and birthing partners.
- The women told us staff gave them the opportunity to discuss different options of pain relief and they had been offered a choice. Women said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed.
- The service provided a 24-hour anaesthetic and epidural service. The trust was unable to provide data on the time women waited for an epidural. 530 women had an epidural between December 2015 and February 2016.
- Clinical records showed pain was assessed throughout labour; and was documented on the MEOWS charts. On ward 13, staff recorded pain scores on the NEWS charts.

Nutrition and hydration

- Breastfeeding initiating rates for deliveries that took place in hospital between April 2015 and November 2015 ranged from 74.9% to 80.2%. This was in line with and at times better than the England average of 76%. Breastfeeding support was provided, and there was an infant feeding coordinator. Clinics were available twice a week for new babies that had difficulties with feeding. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers.
- Ward 21 had a milk kitchen to allow new mums to bring formulas onto the ward and be educated on the correct way to make up feeds.
- All midwives had completed baby friendly initiative (BFI) training and healthcare assistant were trained to support new mums using expression pumps.
- The trust was implementing United Nations Children's Fund (UNICEF) BFI standards and were working towards accreditation.
- On ward 21, meals were served in the dayroom; women could take the meals to their own room if they preferred. Women we spoke with had no concerns about the food and told us that different dietary requirements were catered for.

Patient outcomes

- The trust monitored and recorded patient outcomes on a monthly performance dashboard. The trust had started to participate in a Yorkshire and Humber regional performance dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues. This was in accordance with recommendations of the Royal College of Obstetricians and Gynaecology 2008.
- The National Neonatal Audit Programme (NNAP) included two questions that applied to maternity services. The 2014 report indicated that the trust was achieving 100% compliance with recording babies' temperature within an hour of birth; this was above the target of 98%. The trust achieved 87% compliance for the percentage of mothers receiving a dose of antenatal steroids; this was above the target of 85%.
- The trust did not have any active maternity outlier alerts, 'outlier alerts' are a description used to describe when a service lies outside the expected range of performance.
- The number of births at Airedale NHS foundation trust from July 2014 to June 2015 was 2158. Of these births 65% were normal vaginal deliveries (NVD) which was slightly above the England average of 60.2%.
- The percentage of women aged 20-34 who gave birth at Airedale between July 2014 and June 2015 was 76.8%, which was in line with the England average. The percentage of women under the age of 20 was also in line with the England average.
- Information displayed on the labour ward showed the percentage of caesarean sections in February 2016 was 20.4%.
- Between March 2015 and November 2015 the percentage of emergency caesarean sections ranged from 8.7% to 15.7% which was comparable with the England average of 15.2%. The percentage of elective caesarean sections ranged from 7.7% to 15%, which was slightly higher than the England average of 11%. The

trust carried out an audit of elective caesarean sections and recommendations from the audit included, developing the information women were given to help inform their choice and produce a patient directive to encourage women to have normal vaginal deliveries.

- The percentage of vaginal delivers following a caesarean section between March 2015 and November 2015 ranged from 2.7% to 8.9% against the trust target of less than 6%. The trust held a monthly VBAC clinic to promote vaginal delivery following a caesarean section.
- The percentage of deliveries that required instrumental assistance between March 2015 and November 2015 ranged from 5.9% to 12.1%. This was lower than the trust target of 10% to 15%.
- There were no maternal deaths related to pregnancy care between March 2015 and November 2015. During this period three women were transferred to the intensive care unit (ICU) and four were transferred to high dependency unit (HDU) following deliveries.
- The number of cases of postpartum haemorrhage defined by the trust as more than 2 litres between March 2015 and November 2015 was 17. This was below the trusts target of 5 cases per month. The service also recorded the number of postpartum haemorrhages between one to two litres. From March 2015 to November 2015 the service reported 99 cases. This was below the trust target of 118.
- The percentage of women who suffered from a 3rd degree perineal tears ranged from 0.6% to 4.1% between March 2015 and November 2015. Information displayed on the labour ward showed the number of 3rd degree perineal tears in February 2016 was 2.6%. At times this was above the national average of 2.9%. The service reviewed all 3rd degree tears and produced an action plan where lessons could be learnt. No 4th degree tears were reported.
- The number of stillbirths (defined by the trust as babies over 24 week's gestation) between March 2015 and November 2015 for the trust was 6. There were no unexpected intrapartum foetal deaths resulting in stillbirths**.** The trust had implemented SaBiNE care bundles (focusing on reducing the number of stillbirths) and used customised growth charts to monitor babies' growth during pregnancy to reduce the rate of stillbirth.
- Between March 2015 and November 2015, 17 term babies were unexpectedly admitted to the neonatal unit. This was above the trust target of less than 16.
- We reviewed incident data from the trust, between March 2015 and November 2015; 27 babies were readmitted to hospital up to 28 days following delivery.
- The home birth rate in 2015 was higher than the England average at 1.1%.
- Between December 2015 and February 2016, 27% of women had their pregnancy induced.
- NICE guidelines and Safer Childbirth policy state that where possible, women should be active during labour and move around where this can be achieved. The trust scored better than other trusts in 2015 CQC national maternity service for enabling women to move around and choose a comfortable position.
- Between April 2015 and June 2015 the trust were above target for all screenings including antenatal infectious disease screening and timely referral to specialist, antenatal sickle cell and thalassaemia screening and new-born physical examination. However, the trust was above the 2% target for avoidable repeated new-born blood spot tests at 12%. Staff we spoke with said work was been done with the community teams and new lancets had been purchased to reduce the number of avoidable tests.
- Between September 2015 and February 2016 the rates of maternal infection were low; 3 women were placed on the sepsis pathway, this equated to 0.3% of deliveries.

Competent staff

- At the time of our inspection 91% of staff within maternity and gynaecology had undertaken an appraisal in the last 12 months. The majority of staff we spoke with said they had completed an appraisal or were expecting one in the future. Staff said the appraisal process was valuable and allowed them to discuss their development and learning needs.
- All midwives must have a supervisor of midwives (SOM). Their role is to provide support and guidance for all practicing midwives. National recommendations for the number of SOM to midwives is 1:15. Data from the trust quality dashboard showed this was consistently achieved from March 2015 to November 2015. Midwives we spoke with had a designated SOM. Staff told us they had access and support from a midwifery supervisor and a SOM was available 24 hours a day.
- The local supervisory authority (LSA) report audited the standards set by the nursing and midwifery council and compared current practice. Standards included the

availability of SOM, a current list of SOM, a strategy to enable effective communication between SOM and yearly review of practice and review of learning needs. The audit found the effectiveness of statutory supervision was excellent and recognised improvement the service had made. However, the audit identified five midwives in the maternity unit whose annual reviews were out of date. In the past 12 months data provided by the trust showed that 92% of SOM had completed annual reviews.

- Staff told us newly qualified midwives undertook 'preceptorship' where they went through a programme of competencies and had additional support.
- We reviewed information which outlined the maternity multidisciplinary emergency skills training (Yorkshire and Humber Obstetric Training Study Day; YMET). This covered training on shoulder dystonia, breech, cord prolapse, obstetric haemorrhage, eclampsia, evacuation of pool and adult resus and included two emergency drills. YMET training compliance in 2015 was 100%.
- Medical staff had access to a Managing Obstetric Emergencies and Trauma course.
- Midwifery and medical staff attended a two-day mandatory training programme yearly, this included CTG training.
- On the labour ward one midwife was designated to be a 'scrub' midwife on each shift. The 'scrub' midwife went into theatre for any elective or emergency caesarean sections. Staff told us they had completed 'scrub' competencies and felt confident in undertaking the role. Data provided from the trust showed 10 midwives had completed 'scrub' competencies. We reviewed the competency booklets and saw evidence of a comprehensive skill framework to ensure midwives developed the necessary skills to undertake the role.
- Junior doctors told us they had the opportunity to attend training sessions and participate in local audits. They described a supportive department for training and felt well supported by the ward team and could approach senior colleagues for advice if needed.
- Bank staff told us they had been thoroughly inducted and felt supported.
- Nursing staff on ward 13 had not completed any specific gynaecology training. Staff told us they received one training afternoon on administrating medication to women undergoing medical management of pregnancy.
- Staff said a specialist gynaecology nurse would attend daily ward rounds and support the nursing staff if required and they could contact staff on the early pregnancy assessment unit during working hours.
- Data from incidents reported occasions when following home birth women were admitted to the labour ward for suturing due to community midwives not been competent in suturing. No harm came to the women and staff said they were planning on developing a training programme for community midwives that allowed them to spend two weeks on the labour ward to develop their skills.
- Nursing staff and midwives said they felt supported in the revalidation process.

Multidisciplinary working

- We saw evidence of multidisciplinary working within clinical areas. All necessary staff and teams were involved in assessing, planning and delivering patients care and treatment.
- We found communications with GPs, community midwives and health visitors included detailed summaries of antenatal, intrapartum and postnatal care.
- The neonatal care staff worked closely with the maternity staff and provided an outreach service to the ward to administer intravenous antibiotics to babies and phototherapy. This allowed babies to stay with their mums on ward 21.
- Staff described close working relationships with the obstetric team and met daily to case review all instrumental deliveries and caesarean sections.
- The early pregnancy unit took referrals via GP's, the emergency department or community midwives for women up to 20 weeks gestation. The service was nurse led but on call medical cover was provided by the gynaecological medical team.
- We saw evidence of staff working closely with community staff and GP's when dealing with safeguarding concerns.
- Women who had continence problems following delivery were referred to a specialist physiotherapist who specialised in women's health.
- We saw effective use of the SBAR tool when women were transferred between the labour ward and ward 21.

- The gynaecology oncology medical team had weekly teleconferencing with a neighbouring trust to discuss all gynaeoncology patients. Staff said this enabled the service to streamline patients care.
- Staff said they could access support and advice from specialist nurses/midwives and confirmed there were systems in place to request support from other specialities such as pharmacy, the acute care team and physicians.

Seven-day services

- Access to an obstetric theatre team was available at all times. A consultant anaesthetist was allocated to the labour ward Monday to Friday; an additional anaesthetist was available when the ward had a list of women having elective caesarean sections. Out of hours an anaesthetist was available 24 hours a day, 7 days a week.
- There was medical staff presence on the labour ward during the day and out of working hours a consultant was always available on call.
- There was an on-call rota of SOM. They were available 24 hours a day, seven days a week and provided midwives with support. Staff did not report a problem contacting a SOM.
- The maternity assessment centre was open Monday to Friday from 9:00am to 17:00pm. Staff told us they tried to extend the opening hours if staffing allowed. Out of hours telephone calls were diverted to the labour ward. Staff said this place additional pressure on midwives working on a Saturday and Sunday as they had to care for women on the labour ward and triage women contacting the ward. Staff said on some weekends they could have up to 20 women requiring antenatal care who attended the labour ward with reduced foetal movement and required assessments and CTG's. This placed additional pressure on the staff.
- The early pregnancy unit was open Monday to Friday from 8:00am to 17:00pm but not on a weekend. Out of hours or on a weekend telephone calls were diverted to ward 13. Staff on ward 13 took details of the referral and booked women in to attend the unit during the week, in urgent cases women would be advised to attend the accident and emergency department.

Access to information

- Information relating to discharge was sent electronically to patients GP's, health visitors and community midwives. Staff said they also faxed copies. If concerned about a new mum staff said they would make a telephone call and speak with the relevant professional.
- Staff could access an electronic records system to view any risk factors relating to patients for example, safeguarding referrals.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could access the site and take a virtual tour of the unit. Information was also available about preventing infections, car seat safety and safe sleeping.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on consent the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs) was part of mandatory training for staff. Staff training records showed that 96.5% of staff had completed the training.
- Women told us they were given sufficient information to enable them to make an informed choice about the delivery of their baby.
- Staff we spoke with were able to explain the process of ensuring patient consent was gained and demonstrated an understanding of the MCA. At the time of our inspection there were no patients subject to a Deprivation of Liberty application.
- The trust consent policy made reference to Gillick competency and the Mental Capacity Act. Staff were aware of applying Gillick competency when obtaining consent for women under the age of 18.
- We saw evidence in patients records of consent forms been completed for women undergoing caesarean sections and instrumental deliveries.
- The trust did a limited number of surgical terminations of pregnancies. There was a process in place to ensure women were consented in accordance with the NHS abortion act 1967. However, there were no women undergoing the procedure at the time of our inspection. Therefore, we were unable to check the process had been adhered to.

Are maternity and gynaecology services caring?

Maternity and gynaecology

Good

We rated caring as good because:

- People were supported, treated with dignity and respect, and were involved in making decisions about their care.
- Positive feedback about the care and treatment women had received. People spoke positively about the staff and felt supported and cared for.
- People felt involved in their care and were supported in making decisions.
- Maternity surveys highlighted that the trust performed similar to other trusts and in some areas better in the 2015 maternity survey.

Compassionate care

- Data from the NHS Friends and Family Test showed that between November 2015 and February 2016 on average 96% of women would recommend antenatal care, 100% of women would recommend their birth experience, 98% of women would recommend the postnatal ward and 100% of women would recommend the community postnatal services. All of these are above the England average.
- The maternity service undertook monthly inpatient surveys. Real time survey results for October 2015 showed the service scored well. 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.
- The 2015 Maternity Services Survey, Airedale received 129 responses. 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.
- Data on the women's services quality dashboard showed that between March 2015 and November 2015 maternity services received 205 compliments.
- We spoke with eight women, all of whom spoke positively about their experience. Women told us they felt well cared for and that the midwives made them feel safe. Two women told us they had chosen to give birth at Airedale due to a previous positive experience. Women told us staff were always available if they needed them, staff introduced themselves and promptly responded to buzzer including during the night.
- Comments from patients on ward 21 included: "the midwives could not do enough" and some described the staff as "brilliant".
- We observed staff interacting positively with women and their partners. Women who were over 20 weeks pregnant could contact the maternity assessment centre if they had any concerns. We observed good interaction between staff in the maternity assessment centre and women who were ringing for advice, we heard staff providing encouragement and reassurance to women who were anxious and worried.
- Women said they were encouraged with skin to skin contact following the birth of their child.
- Single rooms were provided for women experiencing pregnancy loss or medical termination of pregnancy.
- On ward 13 staff expressed concerns about the privacy and dignity of women as on occasions the assessment room was used as an extra capacity bed. Therefore women who need intimate examinations could be in a bay with four other women with only curtain partitions between the beds.
- We had concerns about the privacy and dignity of women who needed to be transferred from the maternity assessment centre to the labour ward in an emergency as they had to be wheeled through the main waiting area. Staff said they would clear the waiting area if they needed to transfer a woman in an emergency.

Understanding and involvement of patients and those close to them

- Women said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.
- We saw evidence of staff listening to patients and trying to accommodate their wishes about their preferred place of delivery. From patient records we saw evidence of discussions of the risks and benefits of different birthing locations. For example, a woman who had a previous caesarean section and wanted a home birth.

Maternity and gynaecology

- 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.
- The recent refurbishment on ward 21 enabled partners to stay over with new and expectant mums.
- Vaginal birth after caesarean section (VBAC) clinics were held once a month to discuss birth plans for women who had previously had a caesarean section.
- Antenatal education classes were available for women and their partners. Classes included hypnobirthing, keeping birthing normal and aspects of baby care. Feedback from the sessions was audited and staff reported positive patient feedback.
- Between January 2015 and March 2015 Maternity Services Liaison Committee (MSLC) conducted five focus groups in the Airedale, Wharfedale and Craven area to listen to the views and experiences of new mums and mums to be. A total of 29 people attended over the five focus groups. The majority of the feedback was positive. Women felt they were generally offered a choice of places to give birth, were supported and encouraged with breastfeeding and spoke positively about contact with midwives during pregnancy. However, inconsistencies were reported in the number of women who wrote birth plans, and their experiences during delivery. Some women felt they were left on their own for too long during labour and not assessed enough.

Emotional support

- 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. The bereavement room was away from the main delivery suite and had a small outdoor area. Staff said families could use the room for as long as they needed. The chaplaincy service could also provide support if requested.
- There were no specific counselling services for women who had experienced pregnancy loss. However, staff said women could contact the early pregnancy assessment unit at any time for support and advice.
- Support was given to families for the sensitive disposal of foetal/placental tissue. Staff supported families and enabled them to make an informed choice with burial and funeral arrangements.
- Perinatal mental health assessments took place at the booking appointment, throughout pregnancy and during the post-natal period. Any women who had a suspected mental health illness were referred through the first response team, to the community mental health team for further assessment, treatment and a perinatal mental health care plan.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- People's needs were met through the way services were organised and delivered.
- The needs and feedback from people were taken into account to plan and deliver services to ensure they meet the needs of the local population.
- People were able to access the right service at each stage of their pregnancy. We did find the impact of reducing the number of beds on ward 21 had impacted on patient flow, however the service was aware of this and seeking a solution.
- Women using the service could raise concerns and complaints were investigated and responded to in a timely manner.

Service planning and delivery to meet the needs of local people

- Community midwives carried out routine antenatal care. Clinics were based in GP surgeries or children's centres. Hospital antenatal clinics ran from Monday to Friday for higher risk women. Midwives could refer expectant mums to the hospital antenatal clinic if she developed any problems.
- The service held midwife clinics to support women expecting a multiple pregnancy or suffering with gestational diabetes. These ran alongside consultant led clinics.
- The service ran a stop smoking clinic and a substance misuse clinic once a week for expectant mums.

- The maternity service had a midwife with a specialist interest in teenage pregnancy, a midwife with a specialist interest in bereavement and an infant feeding coordinator; however, they did not have a consultant midwife.
- Women had the option of delivery at home, midwifery led unit or consultant led unit at Airedale hospital. Midwives completed risk assessments with all women on booking of the pregnancy, women assessed a low risk were offered midwife led care. Staff offered higher risk women consultant led care.
- Low risk women who did not want a home birth could give birth on the midwife led unit. This was part of the labour ward and promoted normal vaginal births in or out of water. The consultant led unit was also on the labour ward. Staff could transfer women easily in an emergency.
- We saw evidence of women been given support and good care planning for women who wanted home births following a caesarean section.
- We reviewed patient records and noted that patients booked for midwifery led care did not always have a named midwife. Four women we spoke to also said they did not have a named midwife.
- The community midwifery team spoke of plans to invite patients and stakeholders to an event to gather feedback and suggestions on how to redesign community midwifery services.
- The service acted on feedback from patients and refurbished ward 21 to include facilities that allowed partners to stay over.
- The unit has a dedicated bereavement suite which was well equipped and had facilities for partners to stay over.
- Due to a lack of space on the induction suite, partners could not stay overnight.

Access and flow

- From May 2014 to April 2015 bed occupancy had been consistently lower than the national average with bed occupancy fluctuating between 33% and 42%. In April 2015 bed occupancy increased to 57%, this was following a reduction in the number of bed numbers across the service from 40 to 28.
- The number of beds on ward 21 had reduced to 15, staff told us this had placed more demands on beds and placed more pressure on discharging patients. Senior staff told us they were looking at developing a postnatal discharge lounge on the ward to alleviate some of the pressures and assist with patient flow. This concern was on the local risk register.
- Staff reported there had been delays in admitting women to ward 21 who needed overnight observation and gave examples of when women had waited all day in the maternity assessment centre for a bed.
- Maternity services reported eight closures between September 2014 and March 2016. Senior staff told us that on each occasion a RCA was completed and the outcome of the RCA demonstrated that staff had followed the correct escalation procedure and maintain patient safety. A review of the RCA concluded the closures had been due to heightened activity and increased complexity of the patients and not due to staffing levels.
- In November 2015 the maternity service achieved 91% of maternity bookings before 12 completed weeks' gestation this was above the trust target of 90%. Women received an assessment of their needs at their first appointment. Midwives completed risk assessments at each antenatal visit, and if any new risks were identified midwives updated the women's management plan.
- Community midwives were available, on call, 24 hours a day for home births as required and for cover on the labour ward at times of staff shortages. Staff told us this had not impacted on the home birthing service.
- The maternity assessment centre was open Monday to Friday, 9:00 to 17:00. The maternity assessment centre incorporated day assessment, pre-assessment of elective caesarean sections and triage. Women over 20 weeks could self-refer or midwives and GP could refer women for a range of problems such as reduced foetal movement. Staff aimed to triaged women within 30 minutes of arrival. Staff we spoke with would like a 7 day service and told us about occasions when the centre had closed as midwives were required to support on the labour ward.
- The trust did not collect data on the percentage of women seen by a consultant within 60 minutes during labour. However, none of the women we spoke with reported any delays in seeing a consultant. The trust did record data on the number of women seen by a midwife. We reviewed the data and saw between November 2015 and February 2016 all women attending the labour ward were seen within 30 minutes of arrival.

- Between March 2015 to February 2016, 369 women were transferred from midwife lead care to consultant led care.
- We reviewed the trust incidents and between December 2014 and November 2015 there were eight incidents of babies born before arrival to the labour ward. For each incident the correct guidelines were followed and the incidents were reported as no harm.
- The labour ward had a four bedded induction suite; staff told us they limited the number of booked inductions to three a day. Between January 215 and October 2015 the trust reported 14 delayed inductions. We reviewed these incidents and it was reported this was due to increased activity on the labour ward.
- The Early Pregnancy Assessment Unit provided care for women between six and 20 weeks pregnant and was open Monday to Friday, 9:00 to 17:00. Midwives or GP could refer women or, women could self-refer if they had a history of three or more miscarriages or a previous ectopic pregnancy. Staff said they had good links with the scanning department and had seven scanning slots reserved a day.
- Gynaecology consultants had introduced 'women's half hour'. This was dedicated theatre time every morning to allow any women who required surgical procedures to be dealt with in a timely manner and discharged home promptly.

Meeting people's individual needs

- Women told us they felt their individual needs were met and they felt listened to and able to participate in decisions about their care.
- The trust had a specialist midwife for substance misuse who provided antenatal and postnatal support to patients and supported multidisciplinary meetings in the local community.
- A specialist midwives for teenage pregnancies cared for young women aged 16 and under. Young women had the opportunity to participate in a 12 week 'preparation for parenthood programme'.
- The trust offered stop smoking clinics for pregnant ladies every Monday at the antenatal clinic.
- Staff we spoke with gave examples of how they supported individuals with complex needs and described their role in supporting individuals with learning difficulties. Midwives spoke of having detailed birth plans, involving the patients next of kin/carer and if required social services to ensure the well-being of both mum and child.
- In all areas we visited midwives described how to access translation services through either booking a planned appointment with a translator or using a telephone system called 'the big word'. Staff could provide written information in different languages on request. We saw friends and family leaflets in different languages and written information about pain in pregnancy available in different languages.
- Midwives told us that bariatric equipment was available for women and was easily accessible.
- The service did not have a specialist clinic for perinatal mental health; however, staff said they were planning on developing a satellite clinic in the community. Midwives completed perinatal mental health assessments at the booking appointment, throughout pregnancy and during the post-natal period. Any women who had a suspected mental health illness were referred through the first response team, to the community mental health team for further assessment, treatment and a perinatal mental health care plan.
- Staff told us how they gave families the choice on the disposal of pregnancy remains. The trust could arrange cremation or families could take the remains home.
- Families who experienced pregnancy loss were offered a post mortem. Staff told us the doctors on the unit had been trained by the consultant pathologist to obtain consent from parents.
- Within the antenatal clinic there was a quiet sitting room used by staff to provide counselling to women and their partners following antenatal screening.

Learning from complaints and concerns

- The service reported formal complaints and concerns raised by the Patient Advice and Liaison Service (PALS) on the monthly performance dashboard. Formal complaints were discussed at the women's integrated governance meetings.
- Between March 2015 and November 2015 maternity and gynaecology services had received nine formal complaints and 47 concerns were raised with PALS.
- We reviewed the complaints the trust received relating to maternity and gynaecology services. Common themes included care and treatment during birth and following birth, lack of communication regarding

options of analgesia and aftercare following a caesarean section. Families were given the opportunity to attend a meeting to discuss their complaint and an apology was offered when care fell below the expected standard. We saw evidence of changes in practice following complaints. Examples included; giving partners the option to stay in theatre with women who required suturing.

- We reviewed minutes from clinical governance meetings and saw evidence of discussions about complaints and lessons learnt. On the labour ward lessons learnt were shared with staff using a communication folder. The ward had recently implemented this and not all midwives could give us an example of any complaints or lessons learnt.
- All wards we visited had leaflets about PALS to inform patients about how to raise concerns or make a complaint. Not all women we spoke to knew how to make a complaint but said they would raise any concerns with the staff.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- The leadership, governance and culture promoted the delivery of high-quality patient centred care.
- Governance arrangements were embedded and enabled the monitoring of risk; staff were encouraged to attend clinical governance meetings.
- Staff felt engaged and listened to and spoke passionately about driving service improvement.
- Leaders were visible and accessible and participated in the day-to-day running of the service.
- Performance and outcome data was monitored and reported through the women's service monthly quality improvement account.

However, we also found:

- The service did not have a strategy; there was not a clear statement of vision and values within maternity and gynaecology services.

Vision and strategy for this service

- The trust vision of 'right care' was well embedded in the service and staff were able to articulate what 'right care' meant to them.
- There was no clear short or long-term strategy for maternity and gynaecology services. Senior staff said they had been awaiting the publication of the National maternity review (Better births: improving outcomes of maternity services in England) to inform their future vision and strategy. They planned to benchmark the service against the review and then develop a strategy.
- The service did not have a non-executive director with responsibilities for maternity and gynaecology services. Each non-executive director was responsible for all aspects of quality and improvement.

Governance, risk management and quality measurement

- The local risk register enabled the service to identify and understand risks within the service. We reviewed the local risk register for maternity services, 27 risks were identified, all had a risk rating, existing controls to minimise the risk, and required actions. Risks that we identified on the inspection were on the local risk register, for example; none compliance with NICE guidelines and guidelines been out of date. These had been allocated to clinicians to be updated.
- Performance and outcome data was monitored and reported through the women's service monthly quality improvement account. All areas had targets and it was highlighted if figures were outside of acceptable limits. Any exceptions were discussed at monthly governance meetings.
- The trust had started to participate in a Yorkshire and Humber regional performance dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues.
- Quarterly safety account reports were presented to the medical director or the director of nursing at quality and safety operational group meetings.
- The service held monthly clinical governance meetings. We reviewed the minutes from these meetings and saw evidence of discussion about incidents, the risk register, patient surveys, complaints, key performance indicators, and RCA reports. Previous actions were reviewed and monitored.

- The service had a dedicated midwife responsible for risk and governance who investigated all adverse events and was involved in audits. They fed into the governance process to ensure safe practice and raise concerns.
- Following the publication of the Kirkup report (2015) the service had benchmarked itself against the recommendations. We reviewed the report and saw evidence of actions to be taken and updates, however, no timescales were included. One of the recommendations following the Kirkup report was to identify requirements for continuing professional development of staff. The service ensured this happened through yearly appraisals; data from the trust shows 91% of maternity staff have completed an appraisal.

Leadership of service

- Maternity and gynaecology services formed part of the women's and children's directorate. A director of operations, three clinical directors, a general manager and a head of midwifery led the service.
- Senior staff had access to the trust board and felt listened to; they told us they met on a one to one basis with the director of nursing. However, some staff said there was a lack of presence from the trust board at ward level and were not all aware of members of the board.
- The head of midwifery and matrons were seen in clinical areas and were aware of activity within the service during the inspection.
- Staff spoke positively about the head of midwifery and felt well supported and listened to.
- We saw strong leadership at a local level and ward mangers were aware of the challenges in delivering good quality care and identified strategies to address these.
- The trust was achieving the recommended ratio of 1:15 midwives to SOM, all midwives had named SOM, and 92% had completed annual reviews. Every Wednesday the SOM of the day did a walk round of the unit and spoke with both antenatal and postnatal women.

Culture within the service

- We observed good team working relationships; all staff spoke positively and were proud of the care they delivered. A number of junior doctors enjoyed working on a smaller unit as they felt more part of a team.
- Staff were encouraged to be open and honest, the service encouraged a 'no blame' culture where staff were encourage to report mistakes and learn from them. All staff were aware of the Duty of Candour and were able to give examples of when this had been implemented.
- Staff recognised that during times of heightened activity staff were under pressure but felt that everyone worked together as a team to make the workload more manageable. All staff said having more staff would improve this situation.
- Ward managers had an 'open door' policy to encourage staff to discuss any concerns.

Public engagement

- The service had developed a virtual tour of the maternity ward on the trust website to allow members of the public to see the services and help put expectant mothers at ease.
- The service had launched an Airedale midwife Facebook page where information can be shared between new mums and midwives.
- The trust had a Maternity Services Liaison Committee (MSLC) and representatives from the trust attended Maternity Partnership meetings. Maternity partnership worked with providers and commissioners of maternity services to ensure services met the needs of the local women and families.
- Plans to redesign community services included inviting local people and stakeholders to an event to make suggestions on service improvements.
- We saw evidence of 'you said', 'we did' on display boards relating to the refurbishment of the labour ward.
- Trained volunteers visited ward 21 to support new mums with breastfeeding.

Staff engagement

- Staff told us they felt engaged and involved in service development; they felt their ideas were listened to. Staff said they had been asked about their concerns and suggestions for service improvements.
- The head of midwifery had set up a forum for healthcare assistants to give them a voice and allow them to discuss any concerns.
- Following staff engagement the community midwife team had plans to launch a 'Lucina' team that allowed community midwives to spend two weeks on the labour ward alongside the normality team.

Maternity and gynaecology

Innovation, improvement and sustainability

- Gynaecology consultants had introduced 'women's half hour'. This was dedicated theatre time every morning to allow any women who required surgical procedures to be dealt with in a timely manner and discharged home promptly.
- Maternity services had just launched YAMMER, a private social network that would allow SOM to share confidential information and promote learning from incidents.
- The trust had completed a refurbishment of consultant led labour rooms and developed a milk kitchen on ward 21 to given women and partners the opportunity to practice making up feeds in a home situation.
- Ward 21 had plans to develop a discharge lounge for postnatal women to reduce the pressure on inpatient beds and improve patient flow.
- Staff have put a business case to the trust to increase the early pregnancy assessment unit to a 7-day service.

Services for children and young people

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

Information about the service

Services for children and young people at Airedale NHS Foundation Trust included the children's unit (ward 17) which was a 24 bedded ward that provided inpatient and day case care. Four beds were used as an assessment unit for GP referrals, although if needed they were used as overnight beds. The neonatal unit had 12 cots, three of which could be high dependency or intensive care. The services for children and young people also included children's outpatients, the children's outreach team, community paediatrics and the child development centre which offered services from physiotherapists, speech and language therapists and occupational therapists.

Between September 2014 and August 2015 there were 3,678 inpatient admissions of which 1% were elective, 5% were day cases and 94% were emergency admissions. For patients aged under one year old, the most common reason for admission was "acute bronchitis". For patients aged one to 17, the most common reason for admission was "viral infection".

During the inspection we visited the children's unit, the neonatal unit, the child development centre and children's outpatients, which included the children's outreach team. We spoke with 26 members of staff including nursing staff, medical staff, play staff, administration staff and service leads. We spoke to seven parents/carers and two children. We reviewed 13 sets of records.

Summary of findings

The children and young people's service was rated as good overall. We rated effective, caring, responsive and well-led as good. Safe was rated as requires improvement.

The service had the presence of a paediatric consultant in the hospital 24 hours a day, seven days a week.

Staff were caring and showed compassion. Feedback received from patients and their families was positive.

There were good examples of multidisciplinary teamwork and there were transition clinics in place for those with long term conditions.

Policies and protocols were based on national guidance, although a number were out of date. Staff contributed to audit programmes in order to determine compliance with guidance.

Staff felt well supported by their immediate managers and felt it was a good trust to work for.

Children and young people were encouraged to share their views on the children's unit. Children's services acted on feedback received and showed people how they had acted on that feedback.

There was no documented strategy for the children's services, although they had an annual plan which covered sustainability, quality and improvement. This linked to the trust's 'Right Care' strategy.

Services for children and young people

However, we also found that nursing and medical staffing levels did not meet nationally recommended guidance. Nurse staffing rates frequently fell below the planned level and staff were working extra shifts. No acuity tool was used to determine required staffing levels.

At the time of inspection, there were excessive amounts of community paediatric medical records in an office waiting for dictation. The trust took action and provided information to the CQC on the progress.

There was not a robust system to ensure practitioners were having safeguarding supervision at the required frequency.

There were no facilities for adolescents and older children were nursed alongside younger children.

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Nurse staffing levels did not meet the required standards. There were frequent periods of understaffing. Staffing levels on the neonatal unit, did not meet to patient ratios as set out in the DH toolkit for Neonatal Services (2009) and the British Association of Perinatal Medicine (BAPM) guidelines.
- No dependency or acuity tool was used to calculate safe staffing requirements.
- Medical staffing had been highlighted as a risk on the risk register with inadequate numbers of junior doctors and consultants, and the use of locums. The medical staffing rota was not compliant with Royal College of Paediatrics and Child Health (RCPCH) or British Association of Perinatal Medicine (BAPM) guidelines. The trust were aware of this and recruiting additional staff.
- At the time of inspection, there were excessive amounts of community paediatric medical records in an office waiting for dictation. The trust took action and provided information to the CQC on the progress.
- Systems in place for staff safeguarding supervision were not robust.
- The neonatal unit did not use an early warning score to highlight a child's deteriorating condition.

However, we also found that:

- There were systems in place for incident reporting and staff understood their responsibilities to raise concerns and report incidents. We heard examples of learning from incidents. There had been no recent serious incidents reported.
- Medicines were stored securely.
- Records were accurate, legible and up to date.

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic

protective barriers have been implemented by healthcare providers. No never events or serious incidents were reported by children's services between February 2015 and January 2016.

- There were 138 incidents reported between February 2015 and January 2016. Of these, 101 were recorded as insignificant and 37 were recorded as low harm or minor.
- Staff were aware of how to report incidents on the electronic reporting system. They told us they received feedback from incidents at team meetings.
- Learning from incidents was shared across teams at team meetings.
- Minutes of team meetings and governance meetings were reviewed and incidents were seen to be a standing agenda item.
- An up to date adverse event reporting procedure was in place.
- Staff could tell us of changes in practice that had taken place following incidents. For example, a child had slipped over around the hydrotherapy pool so new guidance had been issued to practitioners to ensure that staff accompanied and supported children around the pool area.
- Recommendations from a serious case review had led to a change in practice with regards to safeguarding documentation. Safeguarding issues were documented on a pink safeguarding form which was kept in the patients records.
- The children's outreach team found that their most common incidents were pressure sores. This led to the development of a pressure ulcer chart and the production of a leaflet for carers.
- Mortality and morbidity meetings were held monthly and multidisciplinary attendance was encouraged. Minutes from the last three morbidity and mortality meetings were reviewed. Attendees were mainly medical staff and senior nursing staff.
- Learning from morbidity and mortality meetings was disseminated at team meetings. Evidence was seen in the minutes of learning points that had been raised from a case and feedback had been given to the nursing team involved.
- Staff were aware of the Duty of Candour and the need to be open and honest with service users and their families. The trust had an up to date Being Open (Duty of Candour) policy.

Cleanliness, infection control and hygiene

- There had been no incidences of methicillin-resistant Staphylococcus aureus. (MRSA) within children's services in the last 12 months.
- All the equipment that we saw looked visibly clean. Equipment not in use had stickers on to indicate cleaning had taken place.
- Monthly hand hygiene audits were undertaken.
- The results of a hand hygiene audit carried out in November 2015 showed 100% compliance of nursing and medical staff.
- A clean hospitals audit undertaken in October 2015, which looked at the general environment, showed an overall performance of 92% for the children's unit and 79.7% for children's outpatients. There did not appear to be any action plan from this audit.
- In the 2014 CQC Children and Young People's Survey, the trust scored 8.6 out of 10 (worse than the England average) in the question of whether the hospital room or ward the child was seen in was considered to be clean.
- Infection prevention and control training was offered. Figures provided by the trust showed that children's service were not meeting the 80% target for this training, with an average compliance rate of 71%.
- Staff told us that toys in all areas, including outpatients and the child development centre were cleaned after use; however no cleaning records were kept to verify this, therefore we cannot be sure this cleaning took place.
- All areas we visited were visibly clean. Alcohol hand gel was available with notices informing patients and visitors to use the gel on entrance to and exit from the departments.
- Staff were seen to adhere to the bare below the elbows policy and were seen wearing appropriate protective equipment to carry out procedures and personal care.

Environment and equipment

- In the 2014 CQC Children and Young People's Survey the trust scored about the same as other trusts for the three questions relating to the environment and equipment. This included questions on if the ward had appropriate adaptations and safety on the ward.
- Safety testing had been undertaken on all equipment observed and was up to date.

- The equipment maintenance assurance records were seen. Repair dates and dates of when the next service was due were documented
- Resuscitation equipment was available in all areas and was checked daily. Records were seen which indicated these checks had been carried out.
- Therapy services told us that on the whole, they had good access to equipment from the equipment store. A funding request would be sent to the clinical commissioning group for more specialist equipment.
- The recovery area for children in theatres was within the same area as adult recovery. Curtains were used to screen children when adults were in the same area.
- The children's unit used the two cubicles closest to the nurses' station for patients needing more detailed observation so that they could be observed more closely. The layout of the ward meant that most of the bed spaces could not be seen from the nurses' station. This could pose a risk if there were more patients needing close observation as they could not be seen so well.
- The neonatal unit had limited space and spare incubators were being kept in one of the rooms used for parents to stay overnight. There were no parents staying at the time of our inspection.
- Space in the neonatal bays did not comply with Department of Health standards (Health Building Note 09-03, 2013). However, it was an old building that was in use before these standards were devised.
- Fridges and freezers used for the storage of breast milk had their temperature checked daily and we saw evidence of this. Temperatures fell within the required temperature range. Staff told us that if the temperature fell out of range they would contact the works department.
- The children's outpatient department was shared with antenatal clinic. Staff told us the clinics ran at different times. The waiting area was small but toys were available for the children.
- The children's unit had a playroom, a sensory room and a separate room for children to eat their meals in if they were able to leave their bed.

Medicines

- Fridge minimum and maximum temperatures were recorded daily. Checklists were seen to confirm this. Temperatures were within the required range. Staff were aware of the process to follow if the temperature fell outside the required range.
- Controlled drugs were handled, stored and recorded in line with national guidance.
- Allergies were clearly documented on prescription charts.
- Out of seven prescriptions we looked at three did not have a weight recorded. This meant that there was a risk that medication could have been prescribed incorrectly as the weight of a child is used as part of the calculation for prescriptions.
- There were laminated cards contained within the nursing records documenting appropriate antibiotic use and doses.
- Contained within the nursing records were quick reference documents for emergency treatment calculations.

Records

- During our inspection we saw excessive amounts of community paediatric medical records in an office waiting for dictation. The secretary told us there were up to 400 records signed out to her. Notes from clinics held up to four months ago were waiting for dictation. There was therefore a risk that information was not shared in a timely manner to ensure safe and effective care for patients.
- The trust had identified this on the corporate risk register, however, it had been recorded on 10 December 2015 that there was no current backlog. We raised this issue with the executive team at the time of our inspection. The trust provided us with a risk assessment and action plan on how to address the situation, which gave timescales for the completion of records. The trust provided information to the CQC on the progress made as part of the actions taken.
- Records were paper based with medical and nursing notes kept separately. The trust was moving towards the use of an electronic patient record.
- Records we reviewed were accurate, up to date and legible.
- Safeguarding concerns were documented on a separate sheet held within the records.

- The World Health Organisation (WHO) surgical safety checklist is a tool to improve the safety of surgery by reducing deaths and complications. Those children who were surgical patients had completed WHO checklists within the records.
- Record keeping audits were carried out to ensure compliance with key performance indicators. Information received from the trust showed an overall compliance summary but did not have any action plans.

Safeguarding

- The trust had in place a named doctor and named nurse for safeguarding.
- The director of nursing was the nominated executive lead for safeguarding. He was a member of the Trust Board and attended Local Safeguarding Children's Board (LSCB) meetings.
- The trust had an up to date safeguarding children and young people policy which had regard to the statutory guidance 'Working Together to Safeguard Children' (DH 2015).
- The policy contained information with regards to Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE), the process to follow for did not attend (DNA) patients and for a possible abduction.
- The policy stated that safeguarding supervision should be a minimum of six monthly.
- Group safeguarding supervision sessions were run every two months and anyone could attend, however there did not appear to be a system in place to ensure that all staff had supervision at least twice a year.
- Staff told us they could access supervision at any time they needed it from the safeguarding nurse.
- Figures provided by the trust showed that 92% of children's nursing staff had up to date training in adult safeguarding and 89% had up to date training in safeguarding children Level 1. This was above the trust's target for training of 80%.
- The intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to Level 3 in safeguarding. Figures provided by the trust showed that 75% of children's nursing staff had completed Level 3 training. This was below the trust's internal target of 80%.
- Staff on the neonatal unit told us that they had previously only been trained to Level 2 and that they were in the process of accessing the Level 3 training.
- The safeguarding team and paediatric medical staff were trained to Level 4 and figures showed 100% completion.
- Staff could explain to us the process they would follow if they had concerns about a child and they displayed the flowchart that was used.
- Access to the wards was via a buzzer, doors were kept locked to prevent unauthorised access.
- The electronic patient system had a flagging system to alert staff to those children where there were safeguarding concerns.

Mandatory training

- Mandatory training was available in subjects such as fire safety, equality and diversity, the Mental Capacity Act 2005 and infection prevention and control.
- Figures provided by the trust suggested that children's services had not achieved the 80% target for training. Overall training completion was at 68%.
- Staff we spoke to suggested that this figure could be due to some staff on long term sick leave and maternity leave that would not have completed the training.
- Staff told us they followed an induction programme when joining the trust and we saw an up to date induction policy.

Assessing and responding to patient risk

- Risks assessments were completed on admission. These included nutritional status, skin care/risk of pressure ulcers and infection risk. These were highlighted in the records as key performance indicators (KPI).
- The children's unit used a paediatric early warning tool (PEWS) to highlight when a child's condition was deteriorating. This tool included guidance on what action to take depending on the score. We saw evidence in the records of appropriate action being taken in response to changing PEWS scores.
- The neonatal unit did not use an early warning tool in line with the decision of the Yorkshire and Humber Operational Delivery Network for neonates. Staff told us that they used their own judgement from experience. When asked how this worked for more junior members of staff they said they would seek advice from other staff members. There was no evidence of any incidents occurring as a result of not using an early warning tool.

- Children requiring transfer to intensive care facilities were stabilised either on the ward (in the treatment room or in one of the cubicles used for high dependency patients) or in theatres. An anaesthetist would attend and stay with the child until the transfer team arrived.
- Staff used regional paediatric critical care guidelines and transfers were carried out by the regional retrieval team.
- We observed a multi-disciplinary handover in which discussions about safety and risks took place.
- Children in theatre recovery were nursed on a one to one basis. Staff told us there was always someone available on shift who was paediatric advanced life support trained. Anaesthetists attended the in- house Airedale Paediatric Emergency Skills course.

Nursing staffing

- 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 twos and one nurse to four patients for over twos.
- Reviewing data provided by the trust, we saw that over 60 days the recommended ratio for staffing was only met on every shift for 13 days. For example, on one day in January there were 11 over two's and four under two's on the ward. This would require four trained staff to meet the ratios. On every shift that day, there was three trained staff.
- The wards displayed the planned numbers of staff against the actual numbers of staff. We saw during our inspection that the children's unit was not meeting the planned level.
- On the children's unit in the winter months there should have been an establishment of five qualified nurses and one health care support worker on a day shift, and three qualified nurses at night. The number of qualified nurses working during the day rarely met the establishment. The average fill rate for December 2015 was 86.1%, January 2016 was 71.9% and February 2016 was 71%.
- Feedback we received from staff was that they were regularly short staffed and ward staff were frequently working overtime to cover the ward.
- No acuity tool was used to determine dependency and staffing numbers.
- Senior members of staff told us that they were in the process of looking at a tool to use and were undertaking a staffing review. Recruitment was underway for more nursing staff. The children's unit had a vacancy rate of 3.6% for nursing staff.
- The children's unit had children admitted with mental health problems that were waiting for beds with the mental health service. The trust holds a contract with a neighbouring trust specifically to provide supervision for children with higher tier mental health needs. These staff have the appropriate skills and training to provide support for these children whilst waiting for an inpatient mental health bed.
- The Department of Health (DH) recommends that all hospitals providing emergency care to children should have a high dependency facility with available children's nurses (DH, 2002, 2006). The DH recommends a ratio of 1:2 nurse to patient ratio with capacity to provide 1:1 care for a child that deteriorates (DH, 2002), which is supported by the Paediatric Intensive Care Society (PICS, 2010). . Staff told us that they would get support from neonatal unit staff if they had a child that deteriorated and needed 1:1 care before they were transferred to another hospital.
- The neonatal unit data showed that the actual staffing levels met the planned level. However, these planned levels did not meet to patient ratios as set out in the DH toolkit for Neonatal Services (2009) and the British Association of Perinatal Medicine (BAPM) guidelines.
- Data provided by the trust showed that out of 57 days the staffing levels were not meeting BAPM guidance on 41 days. For example, cot occupancy showed that on one day in January 2016 there were three intensive care babies, two high dependency and four special cares. This would require five staff to be on shift, but the unit only had four trained staff on an early shift, three on a late shift and two on a night shift.
- We saw an escalation procedure for staff to follow when there were concerns about staffing levels. Staff followed this by escalating staffing problems to the paediatric matron. We saw evidence that staffing issues had been recorded as incidents six times between February 2015 and December 2015.
- The children's outreach team was a small team with one whole time equivalent (WTE) band 7 nurse, 1.2 WTE

band 6 nurses and 0.33 WTE health care support worker. No tool was used to work out staffing numbers and staff told us they were reviewing the service and looking at Royal College of Nursing (RCN) guidelines for staffing which recommend 20 WTE community children's nurses for a child population of 50,000.
- Children's outpatients had cover from a trained nurse and a health care support worker. This met the standard minimum of one qualified member of staff in outpatient departments as recommended by the Royal College of Nursing (2013).
- The children's outreach team and children's outpatient team support each other where needed.

Medical staffing

- 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 put forward to increase the number of acute paediatricians to 10.
- However, acute paediatrics had consultant cover on site 24 hours a day, seven days a week. This was good practice.
- The service leads told us that they had recruited a 12 month contracted locum and that they were interviewing for another locum post.
- The trust had a higher proportion of consultants and junior doctors than the England average. The trust had 55% consultants against an England average of 35%.
- Every child admitted with an acute medical problem was seen by a middle grade doctor within four hours of admission and a consultant paediatrician within 14 hours of admission as recommended in the RCPCH standards.
- The consultants operated a consultant of the week system for the children's and the neonatal unit .
- The neonatal unit was covered by a consultant and a junior grade doctor, who would cover the post-natal ward and the neonatal unit. They did not have the medical middle grade staffing to meet the standards set out in the DH Toolkit for Neonatal Services (2009).
- At least two medical handovers were held each day led by a consultant. Patients on the children's unit and the neonatal unit were discussed.
- Community paediatrics had one full time consultant and three part time consultants. Staff felt their service was getting busier and they were starting to look at their staffing requirements.

Major incident awareness and training

- The trust had in place an up to date emergency preparedness, resilience and response policy.
- The children's unit altered their establishment of nursing staff to cover the winter months, however this establishment was not being met.
- The children's outreach team told us they did not have any official winter management plans but used their own judgement and would ring families if necessary.

Are services for children and young people effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line with evidence based guidance.
- There was a comprehensive audit programme in place with demonstrated implementation of learning from action points.
- Appropriate paediatric pain scoring tools were used.
- Nutrition and hydration were appropriately assessed and managed.
- Our observation of practice, review of records and discussion with staff confirmed effective multi-disciplinary team (MDT) working practices were in place. There were processes in place for transition.
- Staff were aware of their responsibilities with regards to obtaining consent.
- A paediatric consultant was available 24 hours a day, seven days a week.

However:

- A number of policies and guidelines were out of date.
- There was not always a member of nursing staff trained in intermediate life support on each shift.

Evidence-based care and treatment

- Staff had access to policies, procedures and guidelines on the wards as hard copies and electronic copies on the intranet.
- Policies and procedures were evidence based and based on national guidance including National Institute for Health and Care Excellence (NICE) guidance , however many of the policies and guidelines that we looked at were out of date.
- 20 out of 42 policies and guidelines we looked at were out of date. Staff told us that they did not have time to update them. However, we did not see any out of date practice taking place.
- Examples of guidelines seen on the neonatal unit that were out of date were: admission of a baby to NNU; assistance with insertion of a chest drain; lumbar puncture; care and management of a baby born to a HIV positive mother; oral/enteral administration of medicines; performing gastric lavage; care of baby undergoing phototherapy.
- Service leaders told us that they were in the process of updating the policies and guidelines.
- Audits were undertaken to ensure compliance with NICE guidance. An audit had been done for diabetic ketoacidosis when new guidance was published. The outcome of this audit led to a change in where patients were nursed and a reminder to staff to complete neurological observations.
- The UNICEF Baby Friendly Initiative is a national intervention that has been found to have a positive effect on breastfeeding rates in the UK. The neonatal unit did not have UNICEF Baby Friendly accreditation, but had a certificate of commitment to accreditation.
- Therapy services followed NICE guidelines for spasticity. NICE guidelines were discussed in therapy manager's meetings to ensure they were using up to date guidance.

Pain relief

- In the 2014 CQC Children and Young People's Survey the trust scored 9.36 out of 10 for the question: "Do you think the hospital staff did everything they could to help ease your child's pain?" This was better than other trusts.
- A paediatric pain scoring tool was in use.
- Appropriate analgesia for pain management was prescribed.
- Staff told us there was not a specific paediatric pain team but that they would contact the hospital pain team for advice if required.

Nutrition and hydration

- Every child's nutritional status was assessed on admission.
- We reviewed 13 sets of records. Appropriate nutrition and hydration management plans were seen for those patient's that required them.
- The neonatal unit provided breast pumps for breastfeeding mother's to use if required and appropriate storage of breast milk was provided in a milk kitchen.
- Feedback we received from parents and the young people we spoke to suggested that the food was not good. There was not enough variety and sometimes it was cold.
- Allergies and intolerances were not well catered for. We were told that on some occasions the kitchen had not sent any food up for a particular child which had resulted in ward staff having to ring the catering staff in order to try and sort it out. On other occasions, the mum had brought her own food in to ensure her child had something to eat.
- We saw feedback received by the unit from January 2016 to February 2016 from 16 families. Four families left negative feedback with regards to the food.
- Senior staff told us that following complaints about the food they had set up a working group with the catering department to try to address the problems.

Patient outcomes

- The trust took part in the 2013/14 Paediatrics Diabetes Audit. The results from the audit showed that 19% of patients had an 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%.

Services for children and young people

- 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%.
- The trust had identified in the National Neonatal Audit (2013) that they needed to improve on two year follow up of patients and consultants speaking to parents within 24 hours. A new system had been devised in which a form was filled in and signed by the consultant. This was then uploaded on to the computer as a prompt for the two year follow up.
- Staff felt that the results regarding consultants speaking to parents within 24 hours was a data issue and they were looking at ways to prompt staff to complete the data in a timely manner.
- Results from the 2014 audit showed an increase in the score for this area compared to the 2013 audit results, which indicates better performance.
- Audit meetings were held once a month and were driven by NICE guidelines.
- The neonatal unit was part of the Yorkshire and Humber Neonatal Network which provided a clinical forum to share best practice, benchmark and discuss new national guidance.
- Therapy services measured outcomes through the use of questionnaires at the end of assessments.

Competent staff

- 86% of staff in Women's and Children's Services had received an up to date appraisal. This was in line with the trust's average appraisal rate of 87%.
- Staff appraisals were used to monitor performance and training levels, and to identify learning needs.
- Poor staff performance was managed with performance action plans.
- Consultants had annual appraisals and had personal development plans that helped with revalidation.
- The service had a diabetic nurse specialist and had just appointed an epilepsy nurse specialist.
- The head of therapy services met with regional managers to share best practice and ensure they were up to date with practice.
- The neonatal unit always had two staff on shift that had a neonatal qualification.
- The management of surgical parents was by consultant surgeons with support from consultant paediatricians.
- The diabetes team were having problems recruiting to the vacancy for a paediatric psychologist. This had been escalated and placed on the risk register.
- New staff on the neonatal unit undertook a competency package based on RCN standards.
- Out of 24 qualified staff on the children's unit, 13 were trained in intermediate life support and had attended Airedale Paediatric Emergency Skills (APES) course, an in house course. This meant that on some occasions there was not a member of nursing staff on shift that had intermediate life support training. For example, out of 29 days in February there were five days when there was not a member of nursing staff on shift who had intermediate life support training. The RCN (2013) recommends that there should be at least one nurse per shift trained in APLS/EPLS depending on service need.

Multidisciplinary working

- In the 2014 CQC Children and Young People's Survey the trust scored 8.62 out of 10 for the question (asked to parents of children aged 0-15 years): "Did members of staff caring for your child work well together?" This was about the same as other trusts.
- The child development centre worked with children with a range of development difficulties. The team included physiotherapists, occupational therapists, speech therapists and community paediatricians.
- The neonatal unit had access to services from the occupational therapists, physiotherapists, speech therapists and dieticians. However, multidisciplinary ward rounds were not conducted.
- Ward rounds on the children's unit included medical and nursing staff.
- Pharmacists visited the wards every day and there was access to an on call pharmacist at night.
- Neonatal unit staff told us they worked closely with the children's unit and children's outreach team. Multidisciplinary team meetings were held prior to discharge for those children with more complex needs.
- The children's unit employed play staff and teachers. Teachers were on the ward during school hours in term time.
- The paediatric diabetes team had a good relationship with the adult diabetes team and had plans in place for those children making the transition from children to adult services with an adolescent clinic.

Services for children and young people

- Joint clinics between paediatric and adult services were also held for those children with epilepsy and those with a disability.
- Community paediatricians and the children's outreach team had good links with community services such as health visitors and school nurses. They carried out joint visits with health visitors if needed.
- The children's outreach team carried out joint visits with therapists where appropriate.
- The children's outreach team could contact the paediatric consultants for advice and to arrange for access to the children's unit for a patient.
- We saw the pathway for transition to adult services which included multidisciplinary staff.

Seven-day services

- A paediatric consultant was available in the hospital 24 hours a day, seven days a week.
- On call pharmacy support was available.
- The play team on the children's unit were not always available seven days a week. There were two play staff members and one was on long term sick leave. This meant that for three days a week there was no play staff cover.
- The children's outreach team did not work seven days a week, they worked Monday to Friday 9am to 5pm. The RCPCH standards (2015) suggest that an acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week.
- One of the community paediatricians held outpatient clinics on a Saturday.

Access to information

- Electronic discharge letters meant that those GP's who used the same electronic system received discharge notifications as soon as the child was discharged. Those not on the electronic system had a letter sent by post.
- Children's unit staff were able to print demographic information from the electronic system to use for their admission assessment.
- The trust was in the process of introducing the electronic patient record in all areas.
- Staff always had access to records for outpatient appointments.
- In the 2014 CQC Children and Young People's Survey the trust scored 7.3 out of 10 for the question (asked to parents of children aged 0-15 years): "Were the different members of staff caring for and treating your child aware of their medical history?" This was about the same as other trusts.

Consent

- The trust consent policy had a review date of January 2016. Within the policy it made reference to Gillick competency and the Mental Capacity Act.
- Staff were aware of applying Gillick competency when obtaining consent involving young people.
- Staff told us that if they had concerns about a parent's capacity to consent they would speak to the safeguarding team for advice.
- In the 2014 CQC Children and Young People's Survey the trust scored 8.97 out of 10 for the question (asked to parents of children aged 0-15 years): "Did a member of staff agree a plan for your child's care with you?" This was about the same as other trusts.

Are services for children and young people caring?

Good

We rated caring as good because:

- Feedback from children and parents was positive about the way they were treated.
- Staff were observed treating people with dignity and respect.
- Parents and the young people were involved in their plan of care.
- The trust scored the same as other trusts in relation to caring in the CQC Children's survey 2014.

However:

- Parents did tell us that sometimes the staff were very busy and it may take time for them to be seen.

Compassionate care

- The trust scored about the same as other trusts for 20 out of 21 indicators relating to caring in the CQC Children's survey 2014. The remaining indicator, which was better than the England average, was 'Did members of staff treating your child communicate with them in a way that your child could understand.

Services for children and young people

- Between April 2015 and January 2016 the Friends and Family recommendation rate fluctuated between 85% and 100%.
- We observed staff talking to patients and their families in a respectful and considerate manner.
- We spoke to children, young people and their parents on the children's unit, the neonatal unit and in children's outpatients. Staff were described as caring, fantastic, nice and amazing.
- Positive feedback was given about all staff members including nursing staff, medical staff, ward clerks, housekeepers, cleaners and play staff.
- Parents we spoke to on the children's unit said that sometimes the nursing staff seemed very busy and short staffed. This meant that sometimes they would take longer to answer call bells.
- We saw feedback received from children and young people on the children's unit. Feedback they had received said that 'the staff are friendly and kind, take good care of you'. Other feedback said that 'the doctors and nurses were very nice. Everyone who works here is very kind, can trust them'.

Understanding and involvement of patients and those close to them

- We observed staff talking with the children and young people in a way they could understand.
- Parents told us they felt fully informed and included in their child's plan of care.
- 'You said, we did' feedback from parents was displayed on the ward. One of these related to parents wanting more shared information about their child's treatment. The children's unit had therefore placed a poster in each room providing information on how parents could access their child's care plan.
- Parents on the neonatal unit were encouraged and supported to participate in their baby's care.

Emotional support

- Parents told us that they felt confident leaving their children in the care of the ward staff.
- The children's unit had patients that were waiting for Child and Adolescent Mental Health Services (CAMHS) placements. These patients were supported by the ward staff and CAMHS colleagues.
- The trust chaplain visited the wards to provide spiritual, religious and cultural support.
- Bliss champions supported families on the neonatal unit. Bliss Champions provide a vital link between parents, units and Bliss services, ensuring families of premature and sick babies can gain access to the information and support services that Bliss provide.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Children, young people and their families' views were sought and acted upon.
- The creation of an assessment area on the children's unit meant that children did not have to be admitted to the ward.
- The outpatient department and the children's outreach team were undergoing reviews to ensure they were meeting the needs of the local population.
- The children's outreach team facilitated early discharge from hospital.
- There had been no recent complaints. Information was provided to patients and their families as to how to make a complaint.

However:

- There were long waiting times for autism assessments, although this issue had been escalated to the Clinical Commissioning Group (CCG).
- There were no adolescent facilities and older children were nursed alongside younger children. The service was looking at developing a teenage room but there were no specific plans in place.

Service planning and delivery to meet the needs of local people

- Service leads told us that when the children's unit was refurbished patients and their families were involved in the planning.
- The children's unit did not have a separate area for adolescents. This meant that older children and young people were often in a bay with younger children. During our inspection, we saw older children nursed in

bays with younger children. This was not in accordance with national guidance, such as the National Service Framework for Children: Standard for Hospital Service (DH 2003).
- A parent's room was available on the children's unit and the neonatal unit where parents could sit and have a drink and warm themselves a meal.
- Parents on the children's unit were able to stay overnight on camp beds next to their child.
- The neonatal unit had two bedrooms; these were used for parents of very sick babies or for those who were close to discharge.
- The community paediatricians had started different clinics in response to the needs of their patients, such as a Down's Syndrome clinic and a joint clinic with physiotherapists for spasticity.
- The assessment beds on the children's unit meant that children could be referred by the GP to be seen without having to be admitted to the ward.
- Patients had access to the internet whilst in the hospital. The children's unit had a poster on the wall about Facebook and safe use of the internet.
- The children's unit provided a 'Welcome to the Children's Unit' leaflet with information about the ward and hospital facilities.
- The child development centre had problems with leaks and the wallpaper was peeling off in one of the offices. The carpet looked old. The trust was in the process of refurbishing areas of the hospital and staff told us they were due to have the floor outside resurfaced.

Access and flow

- Patients were admitted to the paediatric ward as emergency admissions through accident and emergency or via the GP. A small number were planned admissions. Some patients with complex needs had direct admission to the ward.
- At the time of our inspection there were two patients who were waiting for a mental health placement.
- Service leads told us that they had difficulties with patients needing specialist mental health care accessing beds. They escalated this with CAMHS and completed incident forms.
- Surgical patients were put on morning theatre lists to minimise fasting and waiting times.
- Parents we spoke to in the outpatients department said that they had not encountered any problems when needing to cancel and rearrange appointments.
- The average waiting time for a first outpatient appointment for community paediatrics was 15 weeks. This fell within the 18 week target.
- The NHS constitution (2010) states that people with a referral from a GP should start their treatment within 18 weeks. The target is that at least 92% of people should spend less than 18 weeks waiting for treatment. Figures provided by the trust showed that the trust was meeting this target. January 2016 was 98.2%, February 2016 was 98.3% and March 2016 was 98.6% for all paediatrics. Community paediatrics achieved 97.2% in January 2016, 97.6% in February 2016 and 97.2% in March 2016.
- The provision of services for children needing an assessment for autism was a challenge. The waiting time was approximately 42 weeks. Community paediatrics did not have the capacity to meet the needs and staff felt there was a lack of multi-agency oversight due to factors in partnership organisations that they felt were outside of their control. This issue was on the risk register and had been escalated to the Clinical Commissioning Group (CCG). CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
- Community paediatricians told us that there was a wait for CAMHS referrals of around three to four months. In the meantime they tried to signpost families to other support agencies.

Meeting people's individual needs

- In the 2014 CQC Children and Young People's Survey the trust scored 8.26 out of 10 for the question (asked to parents of children aged 0-15 years): "Did you feel that the staff looking after your child knew how to care for their individual or special needs?" This was about the same as other trusts.
- The child development centre provided services for children with more complex needs and allowed for multidisciplinary assessments to take place. A plan of care for the individual child was coordinated between the therapists.
- The child development centre did not have an accessible toilet for disabled users. If needed, they had to leave the child development centre and access the main hospital.
- Parents of children on the children's unit and the neonatal unit had open visiting, allowing them to be with their children at all times.

- Staff had access to interpreter services if required.
- The children's outreach team provided care at home for a variety of conditions such as metabolic, cardiac, shared care with oncology, and complex needs. They supported families with children on oxygen therapy and those having gastrostomy or nasogastric feeding.

Learning from complaints and concerns

- There were no recorded complaints for the children and young people's service between December 2014 and December 2015.
- Parents we spoke to said that if they felt they needed to complain they would talk to the staff and would feel confident to do that.
- Information was on display as to how to make a complaint, including information in different languages.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- Staff felt well supported by their immediate managers and felt it was a good trust to work for.
- There was a clear management structure for children's services which was understood by staff.
- Children and young people were encouraged to share their views on the children's unit. Children's services acted on feedback received and showed people how they had acted on that feedback.

However, we also found:

- Some risks had not been identified on the risk register or did not appear to have had sufficient action taken by management
- There was no strategy for children's services.

Vision and strategy for this service

- The women's and children's directorate did not have a strategy.
- Service leaders told us they had an annual plan which they presented to the Board. It covered sustainability, quality and improvement. This linked to the trust's 'Right Care' strategy.
- Staff were aware of the trust's 'Right Care' strategy.

Governance, risk management and quality measurement

- There was no specific lead for paediatrics at Board level but service leaders told us that one of the Non-Executive Directors (NED) had an interest in paediatrics.
- The backlog of dictation had been identified as an issue on the risk register but it did not appear that sufficient action had been taken with regard to this. Delays in dealing with this issue may have put children at risk of delays to treatment. We were told that no harm had been identified as a consequence of the backlog.
- There was a risk register in place. Some risks identified on the risk register had been there for a prolonged period of time. For example, a potential risk from the working pattern for nurses working on the neonatal unit had been placed on the register in 2011. When we discussed this with the senior management they said that as there had been no recent incidents, this was due to be removed from the register.
- The matron and clinical directors for the women's and children's directorate were the governance leads. They were responsible for cascading information up to the senior management team and to the clinicians.
- Paediatric clinical governance meetings took place every month.
- Minutes from paediatric clinical governance meetings were seen. Items discussed included incidents, complaints and risks.
- There were 23 risks identified on the services risk register. Service leaders identified their top three risks as: provision of autism services, consultant staffing and locum usage.
- The backlog of dictation, nurse staffing levels and out of date policies were not identified by the service leads as high risks. Nurse staffing on the children's unit had not been identified as a risk on the risk register.

Leadership of service

- There was a clear management structure for children's services. There was a director of operations, two paediatric clinical directors, a general manager, a senior matron and a matron.
- Staff were positive about their immediate line managers.

- Leaders on the wards could not be in a supernumerary role due to staffing issues. This meant that they did not always have time for the more managerial tasks such as updating policies.
- Staff told us that the executive team did walk rounds, however most staff said that they had not seen them.
- Some staff felt that the senior management team were not as visible as their line managers and that they were unsure whether their feedback was heard at a senior level.
- The trust was proactive at developing leaders. They had a rising stars leadership development programme.

Culture within the service

- Staff told us they felt respected and that it was a good trust to work for. They felt part of a team and felt valued by every member of the team.
- Some members of staff had worked at the trust for many years.
- However, results from the 2015 NHS staff survey showed that only 11% of staff in children's services reported good communication between senior management and staff.
- All staff worked towards improving child health outcomes.

Public engagement

- 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.
- In all areas we saw evidence of 'you said- we did'. Children's services acted on feedback received and showed people how they had acted on that feedback. The neonatal unit had received feedback that there were no remote controls for the televisions so they had purchased new ones. They had devised a new visiting policy after parents said they would like their families to visit more.
- Managers told us that they were looking at developing a teenage room and wanted to start a teenage forum in order to engage with adolescents.
- The children's outreach team facilitated early discharge from the children's unit. A review in to the outreach service was due to take place with families to be asked for their opinions.
- An outpatient review was underway. Staff held an engagement event with children and families in December 2015.

Staff engagement

- Staff were encouraged to give feedback via the staff survey.
- Staff on the children's unit had developed the idea of using demographic information downloaded from the electronic system for their admission paperwork.
- The review in to the children's outreach team was to involve views from staff members.

Innovation, improvement and sustainability

- The children's unit had been a highly commended team for two years running at the staff awards.
- The directorate was in the process of reviewing the paediatric outpatients department and the children's outreach service. The aim was to evaluate the current services provided whilst exploring future ways of working and service provision, in line with the Trust 'Right Care' principles.
- The therapy services in the child development centre used iPad's and communication aids. They were looking at using apps, which had already been developed, to help families.

End of life care

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

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. All these services were involved in end of life care at Airedale hospital.

The hospital was built in the 1970's and had 358 beds and employed over 2,600 staff. There were less than the average numbers of hospital deaths for end of life patients. On average 49% end of life patients die in hospital; this figure was 36.8% at Airedale hospital.

Airedale NHS Foundation Trust is an NHS hospital and community services trust. It provided emergency, elective (planned), specialist and community care for a population of over 200,000 people from a widespread area covering 700 square miles within Yorkshire and Lancashire. The area covered included rural parts of the Yorkshire Dales and the National Park in North Yorkshire, reaching areas of North Bradford and North West Leeds and extending into Colne and Pendle in the East of Lancashire.

The area served by Airedale hospital included people living in a variety of communities. The age profile, health and level of deprivation of the population varied. Inner city areas such as Keighley had a younger population, while the older population was concentrated in the more rural areas of Craven and Wharfedale. Parts of Pendle and Bradford are among the most deprived areas in England, whereas parts of North West Leeds and Craven are in the least deprived 20% of areas in the country. Airedale, Wharfedale and Craven had a population older than the national average and as such had higher levels of heart conditions, dementia and stroke.

Specialist palliative care is the total care of patients with progressive, advanced disease and their families. Care was provided by a multi-professional team who have undergone recognised specialist palliative care training. The specialist palliative care team had both a clinical and educational role and led end of life care at the hospital. They provided a seven day face to face service supported by the local hospice, and NHS staff from the community. End of life care was provided within the general ward areas at the hospital; there was no dedicated end of life ward.

The specialist palliative care team (SPCT) provided support and advice for patients with complex needs and symptom management issues at the end of life. The team consisted of a 0.6 whole time equivalent (WTE) consultant who worked three days a week, two full time Clinical Nurse Specialists (CNS) and a 0.6 WTE clinical nurse specialist employed by the hospice on an honorary contract. There was also a 0.4 WTE (15 hours) end of life care facilitator. There was administration support for the SPCT of 25 hours a week. There was also a team of three complex case managers who supported ward teams and facilitated rapid discharge at end of life.

From April 2014 to May 2015 there were 683 deaths at the hospital and 405 patients had been referred to the SPCT

There was a chaplaincy service, a chapel and a Muslim prayer room on site. There were a limited number of family rooms available on the hospital site, where overnight

accommodation for relatives could be provided. There was a mortuary and viewing area. Porters took deceased patients from the hospital wards to the mortuary. Out of hours access to the mortuary was arranged via switchboard and porters prepared deceased patients for viewing out of hours. There was a bereavement office where relatives collected death certificates and were given information.

As part of our inspection, we specifically observed end of life care and treatment on wards and other clinical areas. We looked at eight sets of patient care records, including medical notes, nursing notes and medicine charts and 30 do not attempt cardio pulmonary resuscitation orders (DNACPR). We visited the bereavement service, chapel and prayer room, mortuary, and emergency department (ED). We spoke with 39 staff including ward nurses, the patient's bereavement officer, the mortuary team, doctors, porters, chaplains, the SPCT, other clinical nurse specialists, end of life care facilitators, complex care managers, admin staff, allied health professionals, and senior managers. We also spoke with six relatives and two patients who were receiving care. Before our inspection, we reviewed performance information from, and about the trust.

Summary of findings

We found end of life care services to be good overall. We found;

There was seven day face to face specialist palliative care support available to patients and patients were assessed and care planned and delivered in line with evidence based guidance. There was a commitment to good quality end of life care and staff were trained and demonstrated a consistently good knowledge of end of life care issues. Pain was well managed and patients were treated with compassion, dignity and respect. We consistently heard from staff that end of life care was prioritised based on patient need. Bereaved family and friends were cared for in a sensitive and supportive way by bereavement staff.

The Gold Standards Framework was in use throughout the hospital to support the development of good quality end of life care. Two wards had been successful in achieving an independently validated quality accreditation for the Gold Standards Framework.

We saw technology had been used to enhance the delivery of effective care through the use of an electronic palliative care coordination system. Patients were identified as being in the last year of life and the information was shared with professionals. There were innovative ways to ensure care was centred around patients, for example by use of 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.

There was positive multidisciplinary team work and a high standard of collaborative working internally in the hospital and also externally between the hospital and other services. The specialist palliative care team were part of a Palliative Care Managed Clinical Network. This was a group of care providers, stakeholders and commissioners who were involved in planning and delivering end of life services for patients in a range of care settings. There was good cross boundary working with GPs, equipment stores and community nursing services.

However we also found;

End of life care

Facilities for families and friends could be improved. These were not available on all wards and the route families walked to the mortuary was cluttered, shabby and unpleasant. There were several concerns about the mortuary. The viewing room used for families to see deceased patients was stark and basic. Mortuary staff did not always refer to deceased patients in a compassionate manner. There were risks to continuity of the mortuary service; one staff member had been on call for three months. Mortuary staff were unable to tell us what arrangements had been put in place. We spoke with senior managers during the inspection and they told us they were aware of the situation. After our inspection, senior managers provided us with further detail about arrangements which had been put in place at the time.

There was below the national minimum staffing recommendations for hospital specialist palliative care doctors.

It was difficult to draw conclusions about the responsiveness to patients preferred place of care or death. Around 67% of patients did not have a recorded preference in 2015.

Arrangements for monitoring standards and guidance for staff were poor. Most standards and guidance on the trust intranet were past their review date, some by several years.

Do not attempt cardiopulmonary resuscitation decisions were not always made in line with national guidance and legislation

There had been a lack of engagement Black and Minority Ethnic (BME) communities. This was a concern in to the trust as they acknowledged it was difficult to identify if the trust was meeting the needs of this group of patients at end of life

Are end of life care services safe?

Good

We rated safety in end of life care services to be good overall. We found;

- Incidents were investigated and that lessons learned had been communicated and cascaded appropriately.
- Medication was prescribed appropriately. Prescriptions and administration records were completed accurately and clearly. There were guidelines for medical staff to follow when prescribing medicines at end of life.
- Standards of record keeping were good. Comprehensive risk assessments and individual care plans were in place.
- There were no nursing vacancies in the specialist palliative care team, and there had been continuity of staffing which helped to keep patients safe.

However we also found;

- Standards of cleanliness and hygiene in the mortuary had not been maintained due to there being 50% sickness in the mortuary team for three months.
- Almost a quarter of syringe drivers (23%) were overdue their scheduled maintenance date, one was nine months past the maintenance date.
- There was below the national minimum staffing recommendations for hospital specialist palliative care doctors.

Incidents

- There had been no never events in end of life care. Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers.
- There had been no serious incidents related to end of life care between February 2015 and January 2016.
- Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.

End of life care

- We viewed four incidents relating to patients at the end of life between January 2015 and September 2015. In all cases we saw that these had been investigated and that lessons learned had been communicated and cascaded appropriately.
- Senior staff told us they were informed of all end of life care related incidents and involved in the analysis and review.
- Examples of incidents included a deceased patient being received in the mortuary wrapped in a sheet, without any clothing on; no syringe driver being available in the trust for an end of life patient; the initial refusal of a locum consultant to sign a do not attempt resuscitation form; and anticipatory medication not being prescribed for a patient at the end of life.
- Action taken following the incidents included full investigations and resulted in changes to policies and procedures and improvements in sharing information. Information was also shared at relevant training sessions and staff meetings to ensure changes to the way staff worked was cascaded and lessons learnt were shared.
- Incidents were investigated with the involvement of relevant staff and we saw that they were encouraged to reflect and learn. Staff told us they were involved in discussions about incidents, risks and complaints were discussed.
- In particular staff told us they were given the opportunity to discuss and reflect as a team on the care of patients following death.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We saw that duty of candour appeared on the electronic system as a prompt for incidents graded as moderate or above.
- Staff told us they received training about duty of candour as part of their mandatory training and staff consistently told us that patients and relatives were kept informed when incidents occurred.

Cleanliness, infection control and hygiene

- Staff received training for infection prevention and control as part of their annual mandatory training. There had been 100% compliance with the training attendance for the specialist nurses and consultant in the SPCT.
- We found standards of cleanliness and hygiene in the mortuary had not been maintained. There had only been one member of mortuary staff for the three months prior to our inspection due to long term sickness. Staff told us they were responsible for cleaning the department (including high level cleaning), so this had not been a priority in recent months. The last deep cleaning had taken place in September 2015, six months before our inspection.
- We spoke with senior managers about this; they were aware of the issue and told us they were looking into providing cover. We found this of concern as this had been a problem for several months.
- The floor tiles were stained in the post mortem area and the floor was wet from an earlier post mortem that day. This could indicate poor drainage in the area.
- We saw personal protective equipment (PPE) was available and the post mortem area was separate from the body storage area.

Environment and equipment

- Information provided to us by the trust indicated three out of 13 (23%) syringe drivers were overdue their scheduled maintenance; one had been due for maintenance in June 2015, one in November and one in December 2015. This was contrary to the trust policy 'Process for the procurement, maintenance and disposal of medical devices and equipment'.
- We saw the standard operating procedure for McKinley syringe drivers had been due for review on 8 December 2015. This meant that some systems to keep people safe were out of date.
- There was also a standard operating procedure for discharging end of life patients into the community with a McKinley syringe driver; this had been due for review in November 2013.
- Mortuary staff told us the mortuary store had been almost full on five occasions recently. There was space for 31 deceased patients. Arrangements in place with a neighbouring trust and the public mortuary had been used.

End of life care

- The maintenance of the corridor outside the mortuary was poor. Ceiling tiles were cracked and broken and there were trollies and pharmacy crates on the floor. The windows looked out onto bins and a delivery area.
- We discussed the environment with a senior manager. They said they had tried to get the area cleared previously. They had arranged for the window to be made obscure to hide the delivery area. They said they would look into getting improvements into the area.

Medicines

- We saw medicines in wards and clinical areas were stored safely. Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.
- Patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of pain and other symptoms.
- We looked at five medicine charts and saw anticipatory medicines had been prescribed appropriately. Prescriptions and administration records were completed accurately and clearly.
- Staff told us a business case for electronic prescribing had been approved. There were plans to implement this shortly after April 2016.
- The trust had produced guidelines for medical staff to follow when prescribing medicines at end of life. These included pain and symptom management guidance, anticipatory and the use of syringe drivers.

Records

- We viewed eight care records of patients considered to be at the end of life. We found that the standard of record keeping was good. Risk assessments and individual care plans were in place.
- When a patient was identified as nearing the end of life, a 'personal care plan' was commenced. All of the care records we viewed were completed appropriately, accurately and legibly.
- Most records were safely filed; we saw two sets of care records with loose leaves which were not secure in the notes.
- There were two versions of personal care plans in place. The 'old' one had been found to be lengthy and poorly completed, so the SPCT had introduced a shorter more concise version which was being piloted on five wards for a period of one month before being implemented across the trust. It was printed on green paper to help identify it clearly in patient records.
- The 'new' version was a booklet for the first three days of use, and then loose sheets could be added. We saw there was no space on the sheets for patient names and dates of birth to be written or ID stickers to be applied. We discussed this with members of the SPCT who said they would make amendments.
- We saw comprehensive explanations for decision making. There was some unnecessary duplication of records on personal care plans and in nursing notes.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and we observed staff discussing safeguarding on the wards.
- 100% of the members of the palliative care team had attended mandatory safeguarding training relevant to their role in relation to both adult and children's safeguarding.
- There had been no safeguarding alerts or concerns raised with the CQC for end of life care services.

Mandatory training

- Mandatory training was provided for all staff and the type and level of training was identified as part of individual job roles. Members of the specialist palliative care team had undertaken training in areas such as infection control, resuscitation, infection control, fire safety and information governance.
- The overall compliance with mandatory training (13 training topics) for clinical nurse specialists within the SPCT was 86.5% against a trust target of 80%.
- The overall compliance with mandatory training (14 training topics) for medical staff was 77.7%.
- Mandatory training overall compliance for porters (13 training topics) was 78%, for mortuary staff it was 82% (seven training topics).

Assessing and responding to patient risk

- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good

use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.
- Changes to a patient's condition were recorded in medical and nursing notes and in the personal care plan. Advice and support from the SPCT regarding deteriorating patients was available.
- Specialist palliative care was provided from 9am to 5pm seven days a week. Out of hours, and at the weekend, face to face end of life care was provided by the clinical nurse specialists from the hospital SPCT and also 10 community clinical nurse specialists who staffed an on call rota. There was also specialist support from a palliative care consultant on call who either responded in person or by telephone if patients had deteriorated.
- National Early Warning System (NEWS) scores were used to monitor for patient deterioration. This was a scoring system in which a score was allocated to physical measurements such as blood pressure, temperature, respiratory rate and level of consciousness.
- We saw evidence on personal care plans that when patient's needs increased, staff had assessed and monitored their safety. For example when someone could no longer swallow medication.
- We saw that two elevated NEWS scores out of eight we looked at had not been escalated according to the trust policy. We checked other records but could not see evidence escalation had taken place. No harm appeared to have come to the patients.

Nursing staffing

- The specialist palliative care team had a clinical and educational role and the clinical nurse specialists worked seven days a week. There were two full time clinical nurse specialists in the SPCT (a band 7 and a band 6).
- There was a part time (0.4 WTE) end of life care facilitator who provided training support. There was also a part time clinical nurse specialist from the local hospice, who had an honorary contract to deliver some training and to cover some weekend working.
- There were no nurse vacancies and sickness levels were very low at 0.3% for 2015.
- There had been no use of agency staff in the team. This meant there was there was continuity of staffing which helped to keep patients safe.
- Nurse staffing met the national minimum requirements for hospital specialist palliative care (Commissioning Guidance for Specialist Palliative Care 2012). This is the most recent commissioning guidance.
- The SPCT were led by the consultant and there was a medical matron with responsibility for specialist palliative care.

Medical staffing

- The medical staffing for the hospital specialist palliative care team was one part time consultant who worked flexibly three days per week (0.6 WTE).
- This was below the national minimum recommendations for hospital specialist palliative care (Commissioning Guidance for Specialist Palliative Care 2012), which recommends a full time doctor per 250 hospital beds. Airedale hospital had over 350 beds.
- Face to face cover and telephone advice was available seven days a week from an on call medical rota; the consultants worked one weekend in six.
- The consultant was supported by two other palliative care consultants, one in the hospice and one in the community. They rotated posts every three years.

Other staffing

- There was a team of porters who worked across the trust and who were involved in end of life care. They were responsible for handling deceased patients and transferring them to the hospital mortuary via the 'concealment' trolley.
- There were two mortuary technicians. The sickness rate had consistently been 50% for the last three months before our inspection. One staff member had been on call 24 hours a day for three months. They had been asked to increase their hours from 30 to 37.5 hours in order to provide a full time service Monday to Friday. The staff member was on call Monday to Friday from 4pm when they finished work until 8am the next day when they started work. They were on call 24 hours a day at weekends.

Major incident awareness and training

- We saw evidence that potential risks to the interruption of mortuary services had been planned for. The mortuary had a policy of how to respond in the event of a major incident with fatalities.

End of life care

- There were also procedures in place for times when there were less than five spaces left for deceased patients. This included service level agreements with a neighbouring hospital, city mortuary and funeral directors.

Are end of life care services effective?

Good

We rated effectiveness of end of life care services to be good overall. We found;

- The needs of patients were assessed and care was planned and delivered in line with evidence based guidance.
- The Gold Standards Framework was in use throughout the hospital to support the development of good quality end of life care. Two wards had been successful in achieving Gold Standards Framework accreditation. This is an independently validated quality assurance process to demonstrate high quality care for people nearing the end of life.
- We saw technology had been used to enhance the delivery of effective care through the use of an electronic palliative care coordination system. Patients were identified as being in the last year of life and the information was shared with professionals.
- Pain was well managed and that staff checked the effectiveness of pain relief.
- There had been positive results from the National Care of the Dying Audit for Hospitals.
- Staff were trained and demonstrated a consistently good knowledge of end of life care issues.
- There was positive multidisciplinary team working between all staff we met. There was a high standard of collaborative working internally in the hospital and also externally between the hospital and other services.
- There was seven day specialist nursing cover for patients, and a range of shared information to support staff in giving effective care.

However we also found;

- Most of the electronic standards and guidance for staff were past their review date, some by two or three years.
- Guidelines for symptom management had been due for review nine months before our inspection.
- Do not attempt cardiopulmonary resuscitation decisions were not always made in line with national guidance and legislation.
- An audit of emergency 'crash calls' from January to October 2015 showed 40% of crash calls had been for patients with a DNACPR order in place.

Evidence-based care and treatment

- We found that the needs of patients at the end of life were assessed and care was planned and delivered in line with evidence based guidance.
- In response to the national withdrawal of the Liverpool Care Pathway in 2014, the trust had developed personalised care plans and guidance underpinned by the following; NICE Quality Standards (QS13- Quality Standards for End of Life Care for Adults 2011), National Council for Palliative Care, St Christopher's Hospice, London, Leadership Alliance for the Care of Dying People -Five Priorities of Care for the Dying Person (June 2014), Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020.
- We viewed end of life and palliative care meeting minutes where updated NICE guidance (2015) (National Institute for Health and Care Excellence) was discussed.
- The Gold Standards Framework (GSF) was in use throughout the hospital to support the development of good quality end of life care.
- Two wards had been successful in achieving GSF accreditation shortly after our inspection. The GSF 'Quality Hallmark Award' is an independently validated quality assurance process to demonstrate high quality care for people nearing the end of life.
- End of life patients were 'placed' on the GSF register, and if they were readmitted to hospital, it was automatically flagged to the SPCT.
- The SPCT were taking action to implement six 'ambitions' for end of life care as recommended by Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020.
- This was part of a work plan in conjunction with the Bradford and Airedale Palliative Care Managed Clinical Network. The time frames for completion were due to be finalised in April 2016.
- There had been a local Palliative Care survey from February to April; clinical staff were asked about the effectiveness of the SPCT. The results were due to be collated and reported on by the clinical audit team in May 2016, after our inspection.

End of life care

- We saw technology had been used to enhance the delivery of effective care through the Gold Standards Framework in the form of an electronic palliative care coordination system (EPaCCS). This meant that patients could be identified as being in the last year of life and the information was shared with other teams involved in their care.
- The SPCT had carried out several internal audits in 2014-2015 including the bereaved relatives' audit, a DNACPR audit, and a monthly care of the dying local audit.
- There was a comprehensive internal audit programme for the coming year. This included an audit to see if end of life patients were assessed for depression and the GSF project 'end audit'.
- Staff told us the quality of care at the end of life was now also a part of the updated mortality review process.
- Standards and guidelines were available for staff on the intranet (SharePoint) and an 'app' which staff could download.
- However, we observed most of the standards and guidance were past their review date on both SharePoint and on the app. For example; the symptom management guidelines had a review date of February 2014, the Gold Standard Framework pathway had a review date of October 2014, the 'procedure for discharging patients into the community with a McKinley syringe driver' had been due for review in November 2013. We saw also the Airedale, Bradford, Wharfedale and Craven symptom management guidelines for the Last Days of Life v.1' had been for review in June 2015.This meant that safety systems and monitoring of processes could be improved.

Pain relief

- There were tools available to assess and monitor pain and we saw these in use on the wards.
- Patients and relatives we spoke with told us pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred. Staff checked how effective pain relief had been by asking patients.
- Results of a bereavement survey in 2015 indicated the percentage of relatives who thought pain was well controlled in the last two days of life increased from 87.5% in 2014 to 96% in 2015. The control of other symptoms increased from 82% to 92%.
- Where appropriate patients had syringe drivers which delivered measured doses of medicines at pre-set times. We saw a wide range of registered nurses had been trained in the use of syringe drivers.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed.
- We observed anticipatory medicines were prescribed in line with guidelines.
- Senior staff told us they had not undertaken any specific audits around prescribing of anticipatory medicines; however they participated in local and national care of the dying audits.

Nutrition and hydration

- Nutrition and hydration needs at the end of life were identified as part of the personal care plan (including 'last days of life' care plan) and comfort and dignity care plan. There was guidance for staff on how to discuss this with patients and relatives.
- Assessments incorporated patient choice and comfort and we saw that guidance was based on an individual's ability to tolerate food and drink.
- Patients and relatives told us there was access to food and drink as and when they wanted it. Staff were able to speak with catering staff and request food that patient's wanted.

Patient outcomes

- We found that information about the outcome of patient care was regularly collected and monitored.
- There had been local audits in order to plan for improvements. For example, unannounced 'snapshot' walk rounds by the SPCT and Matron for the area had taken place on the medical and surgical wards in August 2015. Ward nurses and managers were involved in the review of individualised care.
- Three monthly DNACPR audits had taken place and recommendations made based on the results.
- The National Care of the Dying Audit for Hospitals takes place every two years and reports on standards of care for end of life patients and their family.
- We found there had been positive results from the National Care of the Dying Audit for Hospitals (NCDAH).those 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. Examples of the achievements were; seven day access to face to face specialist palliative care, formal training on communication skills to a wide range of staff and having sought bereaved relatives and friends views of care.
- We were told over 90% of patients were seen within 24 hours of referral to the SPCT, that there was always contact with a healthcare professional within 24 hours (who had referred the patient), and that all patients were reviewed face to face within 48 hours. We asked for data to support this, but the trust did not provide it.

Competent staff

- Staff we spoke with on the wards demonstrated a consistently good knowledge of end of life care issues. For example they had a good awareness of the five priorities of care at the end of life and the use of a personal care plan. In addition, many staff we spoke with confirmed they had attended end of life care training and had developed their knowledge and confidence as a result. This included staff nurses, ward managers and heath care support workers.
- We saw all the SPCT nurses had received an appraisal within the last year; however the consultant's appraisal had been due in January 2016.
- One of the SPCT nurses had a Master's degree in Palliative care; another one was part way though the course.
- One team member was undertaking the non-medical prescriber's course, and one was due to begin in September. All the team were experienced and knowledgeable.
- Members of the SPCT attended the annual palliative care conference; this was funded by a trust fund.
- The team were involved in training staff in a variety of ways. There were formal teaching sessions on junior doctor induction programs and the nursing rolling program, lectures and grand rounds.
- There were half day palliative care update sessions for nurses, four times a year.
- Student nurses and pre-registration pharmacy students had learning placements with the team.
- There had been a program of short ward based 'priorities of care' training during 2015. The SPCT developed a short training session which could be delivered on the ward. Training was targeted at nurses, health care support workers, student nurses and junior doctors.
- The trust had delivered 'SAGE & THYME' training to a range of staff. (The SAGE & THYME ® model was developed by University Hospital of South Manchester NHS Foundation Trust. It was designed to train all grades of staff how to listen and respond to patients/ clients or carers who are distressed or concerned).
- 'SAGE & THYME' is a mnemonic which guides staff into and out of a conversation with someone.
- From March to October 2015, over 72% of registered nurses and 79% of healthcare support workers who care for patients in the last days of life had received priorities of care training. Priorities of care training had also been delivered to other allied health professionals and groups e.g. physiotherapists, occupational therapists, dietitians and chaplaincy volunteers.
- Foundation year doctors received two one hour sessions about palliative care, which included the care of the dying person and advance care planning.
- An experienced nurse on each ward had been identified to act as a resource and a quality improvement lead for end of life care, to 'champion' the issues on their ward. Link meetings were held every two months and a quarterly newsletter was sent to all end of life care champions.
- The SPCT had delivered a 'Quality End of Life Care for All' programme (QELCA) to a nominated nurse on nine wards in 2015. The QELCA programme is an initiative funded by the NHS National End of Life Care Programme. It enables health professionals in the NHS to learn about hospice care so they can improve end of life care in their own workplace. There were follow up newsletters and quarterly education meetings for the nurses who had completed the programme.
- Senior staff told us an end of life care competency framework had been developed and was going through approval processes. It was a development aim that all staff groups would be trained and then assessed for their capability in giving end of life care.
- We saw over 30 registered nurses had been trained in the use of syringe drivers for end of life patients. The plan was for these nurses to then cascade training to their colleagues.

End of life care

- Mortuary staff told us told us they had not had any communication skills training to help them in when meeting with bereaved relatives; they told us their 'on the job' training was sufficient.
- Porters told us they had not received any training to prepare deceased patients for viewing out of hours. They said they learned from each other.

Multidisciplinary working

- We observed positive multidisciplinary team (MDT) working between all staff we met. There was a high standard of collaborative working internally in the hospital and also externally between the hospital, community and other services.
- There was a strong cross boundary approach between three consultants; they each worked in the hospital, hospice or community. They met frequently and rotated roles every three years.
- The SPCT were part of the Palliative Care Managed Clinical Network which met monthly and worked collaboratively to take a planned approach to developing services in all care settings.
- The network had members from health, social care and voluntary organisations and met with Clinical Commissioning Group (CCG) leaders. This meant there was a remit to improve end of life care service provision beyond the hospital.
- The local hospice provided a weekly day therapy session at the hospital for end of life patients.
- The SPCT participated in multi-disciplinary meetings and clinics for patients with long term conditions who might be in the last year of life; this was to support decision making with other professionals.
- The SPCT joined in a weekly video call with community staff to discuss patients who were jointly looked after.
- We observed staff working together to assess and plan ongoing care in a timely way for end of life patients who were either transferring to the hospice or being discharged home.
- There was a clear pathway for transfer from hospital to community and evidence that the MDT approach to coordinating care was robust. For example, the team used a shared electronic palliative care coordination system (EPaCCS), and electronic record system. This was a patient care record in use across hospital and primary care services in Airedale, Wharfedale, Bradford and Craven.
- There was evidence of hospital and community teams working supportively, for example, clinical nurse specialists from the community supported the seven day rota so hospital patients could be seen face to face.
- We saw minutes of meetings and groups where a wide range of staff came together to discuss quality and safety issue for end of life care.

Seven-day services

- There was seven day specialist nursing cover for patients between 9am to 5 pm. This was enabled by partnership working with the local hospice, who provided additional funding to allow the services to cover weekend working. Long term funding for this was still being sought.
- Further 24 hour face to face care was available from the on call specialist palliative care consultant out of hours.
- Telephone support for staff was available 24 hours a day, seven days a week from the specialist palliative care consultant.
- There was a 'Gold Line' service which had been set up initially in 2013 with funding from the local and neighbouring CCGs. It was used to improve the safety and quality of care for patients in their last year of life by providing them and their families with dedicated clinical support in their own home or nursing home. This service was available via a 24 hour telephone helpline and video conference service

Access to information

- We saw good provision of information to support staff in giving effective care. For example there was shared information on electronic systems and this information was exchanged between those involved with end of life patients and their families.
- Airedale hospital used the same patient electronic health record' as health services in the community. An Electronic Palliative Care Co-ordination system (EPACCS) was also in use.
- Hospital staff used the Gold Standards Framework (GSF) as a way of identifying people likely to be in their last year of life. When a patient was identified as such, this information was entered into the EPACCs; this enabled a flag to be added to the notes. Staff had access to this information if the patient was re-admitted to hospital.

End of life care

- EPaCCS was held on the telehealth database which the Gold Line service used. This meant all the information staff needed to look after patients was accessible.
- There were plans to link with East Lancashire community health services to improve identification on admission for their patients
- There was a website 'Care towards the end of life' which contained information and advice for patients, carers and professionals on end of life care issues. Content included starting conversations about end of life care, symptom management, living with advanced disease, bereavement support, and benefits advice.
- There was a personal care plan for staff to document care, decisions made and discussions with patients and their loved ones. The document acted as a prompt to staff for to support the care they could deliver.
- A wide range of information was available for staff on the trust intranet via 'SharePoint'. An 'app' was available for all staff to download onto a mobile device. The app contained the same wide variety of end of life care guidance such as;
  - Standards of care for people in the last days and hours of life
  - Professional guidance for care in the last days of life
  - Symptom control guidance for last days of life
  - Supporting care in the last days and hours – a guide for family and friends
  - Bereavement support leaflet and bereavement risk guidance

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- For consent to be valid, it must be voluntary (the decision made by the person themselves) and informed, and the person consenting must have the capacity to make the decision.
- If a person does not have the mental capacity to make a decision about their treatment, professionals can make a 'best interest' decision. However, the professional must take reasonable steps to consult with the patient's family or closest person before making these decisions.
- 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.
- We saw one form had not been countersigned by a consultant for three days. This meant the decision had been made by a junior doctor. A second form had not been countersigned by a senior doctor for two months after the initial decision was made.
- 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.
- We saw minutes of a medical governance meeting which took place in December 2015. There had been an audit of emergency 'crash calls' from January to October 2015. Over that time period 40% of crash calls had been for patients with a DNACPR order in place.
- We saw details of five incidences in October 2015 when the crash calls and some resuscitation attempts were inappropriate.
- We discussed this with senior leaders. It was acknowledged there was room for improvement in this area. The SPCT consultant reviewed all resuscitation attempts with the trust resuscitation officer. A root cause analysis was carried out each time and the findings were discussed at the quality and safety group so learning might take place from the incidents. Senior staff told us learning from such incidents was sent to appropriate staff by email.
- We saw the Mental Capacity Act had been used in relation to one end of life decision; there was evidence in records that a 'best interest assessment' had taken place for a patient without capacity or family to be involved in the discussion.
- The policy for 'Mental Capacity Act including Deprivation of Liberty Safeguards (Adults 16 years* or over) had been due for review in February 2016.

End of life care

Are end of life care services caring?

Good

We rated end of life care services to be good overall. We found;

- Patients were treated with compassion, dignity and respect by staff we met and observed.
- Staff responded to pain relief and distress in a compassionate and timely way.
- Bereaved family and friends were cared for in a sensitive and supportive way by bereavement staff.
- Patients and family members felt they had been involved in their care by staff using the personal care plan and the dignity and comfort care plan.
- The Gold Standards Framework was in use throughout the hospital to support compassionate end of life care.
- Chaplaincy support was available to provide psychological, emotional and spiritual support to patients, families and staff.

However we also found;

- Bereaved families could feel rushed if they were viewing their loved one close to the mortuary closing time of 4pm. Mortuary staff also referred to deceased patients as 'it' several times during a conversation.
- There was a wipe clean reinforced 'bag' which was sometimes used to transfer deceased babies or very small toddlers to the mortuary. We found this was not a dignified method to use.

Compassionate care

- Patients were treated with dignity, kindness and compassion. Patients and relatives we spoke with told us that staff were professional, supportive and kind. We observed care being provided and saw that patients were treated with compassion, dignity and respect.
- There had been end of life weddings recently carried out in the hospital chapel and staff gave their spare time freely to support the patients and families.
- One patient told us staff always respected their dignity when giving intimate care.
- We saw messages in the Muslim prayer room 'memory' book thanking staff for taking cultural and religious needs into account at the end of life.
- We observed staff responding to pain relief and distress in a compassionate and timely way.
- Porters told us they treated deceased patients with respect. They said it was important to still give dignified care and be compassionate to family who visited deceased patients in the viewing room out of hours.
- We had some concern that bereaved families could feel rushed if they were viewing their loved one close to the mortuary closing time of 4pm. Mortuary staff also referred to deceased patients as 'it' several times during a conversation. After our inspection we pointed this out to senior managers who apologised and told us mortuary staff had received compliments from family members about respectful and dignified care and that out of hours viewing could be arranged.
- The bereavement officer demonstrated a sensitive and supportive manner to families who came to the hospital. Staff told us women who knew they would have a stillbirth sometimes asked to see the bereavement officer beforehand.
- The bereavement officer went the extra mile and often worked beyond the expectations of their role to ensure families were supported. They had won a 'pride of Airedale' award for this.
- The trust had arrangement with the Registrar (of births, deaths, and marriages), to come to the hospital three mornings a week so local families did not have to travel to register the death of their loved one. If they didn't want to return to the hospital, they didn't need to do so.
- We saw results of a bereavement survey published in December 2015. Some of the findings included;
- An increase in the number of patients being cared for in a side room in the last two days of life, from 64% in 2014 to 83% of patients in 2015; however 11% of relatives felt that there was not enough privacy for them and their relative in their last days.
- Respondents felt that nurses always (100%) treated their relatives with respect all the time which was an improvement from 95% in 2014.
- There had been one incident in 2015 showing a lack of compassion and dignity when a deceased patient was transferred to the mortuary without clothes, and wrapped in a sheet. A full investigation followed and information shared to learn lessons from this.

End of life care

- There was a wipe clean reinforced 'bag' which was sometimes used to transfer deceased babies or very small toddlers to the mortuary. We found this was not a dignified method to use.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved with the care delivered. Two relatives told us they had been given as much information as they needed and had access to open visiting.
- Four out of five relatives we spoke with said they had been offered car parking concessions.
- We saw that specialist staff discussed care issues with patients and relatives and these were clearly documented in patient's notes.
- Mortuary staff told us patient wishes for organ or tissue donation were respected; there were prompts for staff to ask patients and family about this on the last days of life care plan.
- The personal care plan and the dignity and comfort care plan both included prompts for discussing issues of care with patients and relatives. Family and friends were encouraged to use the relatives and friends communication section of care plans and to be part of decision making.
- The Gold Standards Framework (GSF) was widely used throughout the hospital to support the development of good quality end of life care. The GSF is designed to help involve people in the planning of their care.

Emotional support

- We observed people's emotional needs were assessed routinely as part of end of life care.
- Support was available from the chaplaincy and ward staff; we saw this was readily available to patients and their relatives at the end of life.
- Bereavement support was provided to relatives and friends patients by the bereavement officer. Specialist palliative care nurses had all been trained in advanced communication and could also provide bereavement support.
- The SPCT gave bereavement follow up to all family or friends of patients who had been known to the service.
- We saw positive feedback from families that the chapel and prayer room were open and available 24 hours a day.
- Four staff told us spiritual care was an important part of how they looked after people who were dying and their families; staff understood spiritual care to be about concerns, significant relationships as well as discussion about faith or beliefs.
- The trust complied with the standards for chaplaincy staffing (NHS Chaplaincy guidelines-Promoting Excellence in Spiritual Care 2014). 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. There was no formal arrangement for out of hours chaplaincy cover; switchboard staff contacted the chaplain who ensured either themselves or a non-hospital chaplain could respond.
- The chaplaincy team told us it was more important to provide psychological, emotional and spiritual support to patients, families and staff rather than concentrating on religion.
- There were memorial services, known as a 'service of light' twice a year. Relatives were invited for tea and biscuits; a service in the chapel followed for those who wished to stay.
- Three staff told us they felt they didn't have enough time to spend with patients and provide the emotional support to meet their needs.

Are end of life care services responsive?

Good

We rated the responsiveness of end of life care to be good overall with some outstanding elements. We found;

- Involvement of other organisations in how service were planned to meet the needs of end of life patients. The SPCT were part of a Palliative Care Managed Clinical Network. This was an association of care providers, stakeholders and commissioners who were involved in planning and delivering end of life services for patients in a range of care settings.
- There was evidence of continuity of care when patients were transferred or discharged from hospital.

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.
- End of life care was coordinated with other services so that patients received the care they needed. There was cross boundary working with GPs, equipment stores and community nursing services.
- There was seven day face to face SPCT support available to patients.

However we also found;

- The trust could not provide us with evidence to support responsiveness to referrals to the SPCT. We were told over 90% of patients were seen within 24 hours of referral to the SPCT, we asked for data to support this but the trust did not provide it.
- Complex case managers did not collect information to show how responsive they were in coordinating rapid discharges for end of life patients. This meant the service did not know how responsive it was to patient's needs and wishes.
- The viewing room in the mortuary used for families to see deceased patients was deliberately non-denominational, however it was stark and basic; there were bare walls and no natural light, senior staff told us it was last updated 11 years ago. We discussed the environment with a senior manager. They said they would look into getting improvements into the area.
- Facilities for families and friends were not available on all wards.
- It was difficult to draw conclusions about the responsiveness to patients preferred place of care or death. Around 67% of patients did not have a recorded preference in 2015.
- All respondents to a 2015 bereavement survey had identified themselves as White British. There had been a lack of engagement Black and Minority Ethnic (BME) communities. This was a concern in to the trust as they acknowledged it was difficult to identify if the trust was meeting the needs of this group of patients at end of life.

Service planning and delivery to meet the needs of local people

- Specialist palliative care services were designed to meet the needs of a local population of 200,000 people. Demographic data was taken account of in the local end of life care annual plan.
- Senior staff told us there were around 1500 deaths a year in the local area and 1200 of those were predictable. A variety of methods had been used to register people on the GSF register. For example, collaborative work had been done with all the GP practices and 30 local care homes that used the GSF. This meant patients likely to be in the last year of life could be identified and plans put in place.
- If a patient died in hospital who had been on the GSF, the bereavement officer collected information for the SPCT to help use the information to plan future services.
- There was a service level agreement with Bradford and Airedale Community Equipment store (BACES) to deliver equipment such as beds and mattresses within six hours for end of life patients.
- Arrangements were made with community nurses in East Lancashire for patients from that area who needed equipment for use at home.
- The SPCT were part of a Palliative Care Managed Clinical Network. This was an association of care providers, stakeholders and commissioners who were involved in planning and delivering end of life services for patients in a range of care settings. This meant there was evidence of continuity of care when patients were transferred or discharged from hospital.
- We found there was flexibility and choice for patients who used the Gold Line service. This was a proactive way of providing them and their families with dedicated clinical support in their own home or nursing home after they were discharged from hospital. This service was available via a 24 hour telephone helpline and video conference service. Some patients had been loaned 'iPads' to enable them to communicate with professionals.
- In November 2015, Gold Line had a caseload of just under 1150 patients thought to be in the last year of life from three CCGs with a population of 500,000. The Gold Line took approximately 500 calls a month from patients over the phone or using the iPads.
- There was an established end of life operational group with representation from board level, relevant clinical services, governor and patient and carer panel. The group received and considered reports in order to recommendations with regard to end of life care.

End of life care

- The local demographic showed a population older than the national average and as such had higher levels of heart conditions, dementia and stroke. In order to meet the needs of the population, the SPCT had worked with other services to meet the needs of those groups of patients.
- From April 2014 to May 2015 there were 683 deaths at the hospital and 405 patients had been referred to the SPCT
- The percentage of non-cancer patients had increased from 27% (108 patients) in 2013- 2014, to 31% (125 patients) in 2014- 2015.
- There were facilities for families such as relative's rooms and recliner chairs, although these were not available on all wards. This had been acknowledged by the trust as a 'gap' in their provision for families.
- We saw there was a 'dignity room'; (which was a store of new clothes items and footwear for patients who did not have these items to travel home in) the storage area also contained 'comfort packs' of toiletries and other items for families to use if they wanted to stay overnight at the hospital.
- Mortuary staff told us they previously carried out 60 post mortem examinations a year. This service was due to end in April 2016 when all post mortems would be carried out in the public mortuary.
- Facilities for bereaved relatives were very basic. The maintenance of the area families walked through on the way to the mortuary was poor. The viewing room in the mortuary used for families to see deceased patients was stark and basic; there were bare walls and no natural light, senior staff told us it was last updated 11 years ago.
- All respondents to a 2015 bereavement survey had identified themselves as White British. There had been a lack of engagement Black and Minority Ethnic (BME) communities. This was a concern to the trust and they acknowledged it was difficult to identify if they were meeting the needs of this group of patients at end of life.

Meeting people's individual needs

- There were 'flags' on the electronic records system to identify if a patient living with dementia or learning disabilities was admitted to hospital. Staff told us if people from these patient groups were admitted, they would work with the practice development sister or patients own key workers to ensure their individual needs were met.
- Patients and relatives we spoke with told us staff were responsive to their needs. They told us when they were in pain staff were quick to respond to requests for additional medicines when pain occurred.
- The first dose of syringe driver medication was made up on the ward by nursing staff; this meant patients did not have to wait for medication to arrive from pharmacy.
- We saw positive efforts had been made to take account of people's needs and circumstances in the form of a bereavement survey carried out in 2015. The trust acknowledged in the survey there had been a lack of engagement with Black and Minority Ethnic (BME) communities, and it was difficult to identify if they were meeting the needs of this group of patients.
- Development aims for 2016 were to take part in engagement work around ensuring the service was meeting the needs of BME groups around care in the last days of life.
- Procedures were in place when families wanted deceased patients to be 'released' from the mortuary within 24 hours (including out of hours) for cultural reasons.
- The bereavement officer told us interpreting services such as translation or British sign language had been used as necessary when giving families information after their loved ones death.
- We saw there was no specific concealment trolley to transfer deceased bariatric patients to the mortuary; they were taken on a bed.

Access and flow

- There was a clear referral process to the SPCT and referrals were prioritised based on assessed patient need.
- The specialist palliative care team aimed to respond to all urgent referrals within 24 hours and all non-urgent referrals within 48 hours (including weekends).
- We were told over 90% of patients were seen within 24 hours of referral to the SPCT, that there was always contact with a healthcare professional within 24 hours (who had referred the patient), and that all patients were reviewed face to face within 48 hours. We asked for data to support this but the trust did not provide it.

End of life care

- There was a seven day SPCT service and ward staff told us they knew how to contact the team at weekends and out of hours.
- Preferred place of death was recorded on personal care plans and this information was collected by the SPCT. In 2014, over 26% of patients had a recorded preferred place, this increased to 33% in 2015. However, this meant 67% of patients did not have a recorded preference.
- The SPCT carried out a small audit of 30 sets of notes from patients who had died between 1st January and 23rd March 2015. Results showed 13 patients (43%) had a preferred place of death recorded; for 17 patients (57%) their preferred place was not recorded.
- Seven patients had preferred not to die in hospital. The audit showed they were all transferred or discharged to their preferred place.
- We found this was a very small sample for an audit. It had not been repeated since March 2015; we found it was difficult to draw conclusions about responsiveness to patient preference from such a small sample.
- We saw a bereavement survey in 2015 indicated over 92% of relatives thought their loved one had died in the right place compared to 76% the year before.
- The trust acknowledged there was work to be done to support clinical teams to handle difficult conversations with patients, and ensure accurate documentation of this.
- A team of complex case managers were involved in rapid discharge (fast track) at end of life. The discharge home or transfer to another care setting was coordinated by the case managers who assessed the patients' needs and liaised with the CCG for fast track funding.
- Complex case managers told us patients who lived in rural areas were not always able to achieve their wish to die at home as care services were not available in their area.
- When the funding was approved (usually the same day) the case managers ordered equipment such as a hospital bed and mattress, and worked in conjunction with the 'hospice at home' team (for Bradford patients), or the Airedale or Craven Collaborative Care Teams to ensure a package of care was arranged and ready in a timely way.
- There was an agreement with the ambulance service for transport to a patient's home or other care setting at the end of life. Ambulances could be requested to collect the patient within a two, three or four hour time frame. If they could not respond, the bed manager contacted an independent ambulance provider to act in response.
- Staff told us they had been successful in rapid discharge from outpatient areas without the patient having to be admitted to hospital.
- We found the case managers did not collect information to show the percentage of fast track patients who were discharged within six hours, or on the same day, or any time period after that. This meant the service did not know how responsive it was to patients need or wish for rapid discharge. We spoke with staff about this and were told it is something the team would take forward.
- We also saw this had already been discussed at the end of life operational group in November 2015. There was a plan then for the case managers to liaise with the CCG around ways of recording any consistent delays in the fast track process.

Learning from complaints and concerns

- There had been one complaint about end of life care related to the mortuary.
- It was logged as an adverse incident after the complaint was received. Senior staff told us the issue had been raised at the appropriate governance meetings and the complaint had been dealt with according to trust procedures.
- Senior staff told us up to January 2015 the SPCT used to receive a copy of any complaint or concern which was coded as end of life by PALS (Patient advice and liaison service). This included concerns raised around care in hospital and after the patient died.
- The SPCT previously used themes from concerns and complaints in education sessions to support learning.
- Since April 2015 the complaints reporting system changed; the SPCT no longer received information. Senior staff told us there was a risk that themes around end of life care complaints and concerns were not being detected. They told us this had been raised at departmental level.
- Staff told us that complaints, concerns and compliments would be taken back to the weekly team meetings and we saw evidence of this in meeting minutes.

Are end of life care services well-led?

End of life care

Good

We rated well led for end of life care to be good overall. We found;

- There were several examples of innovative practice. There was a methodical approach to working with other organisations to improve end of life care for patients.
- There was a clear annual plan with timed actions and objectives which were monitored by partner organisations.
- Staff were aware of the vision and values of the service, they told us their goal was to get care right the first time and to make care count for the patient and their family.
- Systems for reporting were in place and the results of audits and surveys were fed from the operational group to the trust wide quality group in order to manage performance of end of life issues.
- Clear and positive leadership was evident within the specialist palliative care team and we saw that supportive relationships were encouraged.
- There was a commitment to good quality end of life care; there had been positive results of the National Care of the Dying Audit for Hospitals (NCDAH).
- We consistently heard from staff the end of life care was prioritised based on patient need.

However we also found;

- There was no specific local end of life strategy for the trust although this did not seem to impact upon patient care as staff knew the standard of care which had to be given to patients..
- Arrangements for monitoring standards and guidance for staff were poor. Most standards and guidance on the trust intranet (SharePoint) and an app designed to guide staff to relevant care or the prescription of medicines, were past their review date, some by several years.
- There were risks to continuity of the mortuary service; one staff member had been on call for three months. Senior managers had been aware of this and had put some other arrangements in place. Mortuary staff had been unable to tell us during our inspection what these arrangements were. After our inspection, senior managers provided us with more detail.
- Governance arrangements needed improvement to ensure inappropriate emergency 'crash' calls (for patients with a DNACPR order in place) did not take place.

Vision and strategy for this service

- There was no local end of life care strategy at Airedale hospital. However, there was a strategic plan and a clear annual plan. Senior staff told us the trust wide 'Right Care' approach applied to all patients. They said this was a health and social system-wide approach to care with the patient, around the patient and for the patient, which was driven by individual need.
- The trust had signed up to the CCG five-year forward view (2014-2019) which included some plans for end of life care.
- There was expected to be a 44% increase in patients over the age of 85 in the coming years, and as such the SPCT were aware their service would need to adapt accordingly.
- The SPCT were key members of the regional Palliative Care Managed Clinical Network. Instead of a strategy, part of the work plan of the network was to implement six 'ambitions' for end of life care as recommended by 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'.
- There was a robust local annual plan with objectives and the absence of a local strategy did not seem to impact on the care end of life patients received.
- The annual plans were monitored by the Managed Clinical Network, the CCG and the trust board.
- When we spoke with staff and asked them what the vision for end of life care was, they told us it was to get care right the first time, to be responsive to patients needs and to make care count for the sake of the patient and their family.

Governance, risk management and quality measurement

- Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.
- An end of life care operational group was formed at the end of 2014; it had representation from clinical staff,

executives and patients' .The group met on a quarterly basis to consider how the trust was delivering end of life care in relation to quality standards, requirements of CQC and other national recommendations.
- The results of audits and surveys were fed from the operational group to the trust wide quality and safety group and other relevant governance groups for agreed action.
- The SPCT was part of the specialist medicine directorate. There was no specific end of life risk register; instead issues were reviewed on directorate risk registers where appropriate.
- Because the end of life care ranged across services in the hospital, there was representation from the SPCT at a variety of quality meetings, including the quality and safety operational group.
- We found there was a programme of both internal and external audit which was used to monitor quality of care.
- We were concerned about arrangements to monitor information used as standards and guidance. Almost all the guidance on the intranet (SharePoint) and the app were past their review date, some by several years.
- There were risks to continuity of the mortuary service; one staff member had been on long term sickness leave which left the other staff member on call for three months with some resilience in place.
- Governance arrangements needed improvement to ensure inappropriate emergency 'crash' calls (for patients with a DNACPR order in place) did not take place. From January to October 2015, 40% of these calls were inappropriate.

Leadership of service

- We observed clear positive leadership for end of life care from the palliative care consultant and the clinical nurse specialists. The consultant was visible, approachable and had the capability and experience to lead the team effectively.
- The specialist palliative care team had sound knowledge and skills and demonstrated supportive working relationships.
- We saw that senior staff prioritised end of life care and that there was a commitment to good quality end of life care. All staff we spoke with in leadership roles had a good understanding of the importance of high quality end of life care and we consistently heard from staff that end of life care was prioritised based on patient need.
- We saw evidence of the whole SPCT provided end of life care leadership across all services within the trust, extending to external services including GPs and care homes.
- The clinical and executive lead for end of life care was the medical director. They told us their role was to ensure the board was cognisant of end of life issues, to help break down barriers and to have senior conversations around end of life care. There was also a non-executive governor with end of life care responsibilities.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- We found a collaborative culture and a shared responsibility to give quality care across all settings.
- Four porters told us they had not seen the chief executive in seven years. They said they had an important role in end of life care yet did not feel this was acknowledged by senior managers.

Public engagement

- We saw people's views about the service were collected in the annual bereavement survey. There was evidence in minutes of meetings this information was used to plan for improvement.
- We saw that patients and those close to them were actively engaged and involved in decision making and we saw evidence that their views were listened to, for example one relative told us the staff were careful not to be intrusive, yet the family felt they needed more support. The family spoke with staff and from then on received what they described as 'the right amount of care'.
- Another family member told us the recording of NEWS observations was meant to have been stopped for their loved one who was dying but staff continued to record these until the family reminded staff. They praised how they were listened to.

End of life care

- The service participated in the NHS Friends and Family Test (FFT). The FFT was created to help care providers and commissioners understand whether their patients and relatives/ friends were happy with the care provided or where improvements are needed.

Staff engagement

- Staff told us they felt actively engaged with the SPCT and felt able to share their views with confidence in relation to being listened to.
- Members of the SPCT told us they felt engaged with the service and able to express their views with confidence of being listened to. They said they could approach very senior managers if they had concerns.
- Three senior ward nurses told us they were concerned their staffing levels were insufficient to provide quality care at the end of life. They said they had escalated these issues to Matrons and felt unsupported at times over this issue as no apparent action had been taken.

Innovation, improvement and sustainability

- The SPCT were focused on continually improving the quality of care. They worked closely with other providers to ensure that services across the locality continued to improve in order to meet the end of life care needs of patients and those close to them.
- Examples of innovation included the development of an app designed for all healthcare professionals within the trust to use. The app, which could be downloaded free onto mobile devices, was intended to help staff to understand the priorities of care, and offered advice on medication prescribing and breaking bad news to people.
- In May 2015, the SPCT was part of the Palliative Care Managed Clinical Network which won British Medical Journal team of the year in the category for compassionate care for patients at the end of life.
- Shortly after our inspection, two wards received two wards had received GSF accreditation. The GSF 'Quality Hallmark Award' is an independently validated quality assurance process to demonstrate high quality care for people nearing 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 SPCT was also part of a partnership in another Vanguard scheme where objective is to enhance the quality of life, and end of life experience of thousands of nursing and care home residents in the area. One anticipated benefit of this was that people would not be unnecessarily admitted to hospital at the end of their life.

Outpatients and diagnostic imaging

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

Information about the service

Airedale NHS foundation trust provides services to Airedale and the local areas.

Between September 2014 and August 2015 there were 235,687 outpatient attendances.

Outpatients was part of the surgical directorate. Each outpatient department or speciality ran a wide range of clinics. There were visiting consultants for maxillo-facial, ophthalmology, ear, nose and throat, orthodontics, plastics and dermatology, although dermatology was returning to another provider in September 2016. Audiology provided outreach services at a number of locations.

Diagnostics included services such as diagnostic imaging services and pathology.

Diagnostic imaging provided services at Airedale hospital in the main department and had imaging services available in accident and emergency. X-rays and scans were performed across four different locations; Airedale Hospital, Skipton General hospital, Keighley Health Centre and Ilkley Coronation Hospital. We inspected Airedale and Skipton hospital outpatient and diagnostic imaging services. The radiation protection advisor role was carried out by medical physics based at another NHS foundation trust. The radiation protection committee met twice a year.

We inspected the main outpatient department, ophthalmology, ear, nose and throat (ENT), women's health, surgical, medical, dietetics, maxillo-facial m, fracture, dermatology, cardiology, diabetes and endocrinology, and phlebotomy clinics. During the inspection, we spoke with 46 members of staff. We spoke with 51 service users and carers. We looked at nine patient records during the inspection.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging as good overall because:

- There had been no never events between February 2015 and January 2016. Incidents were reported and staff knew how to report incidents.
- All areas visited were clean and tidy. The environment was suitable and the required equipment was available. A managed equipment service was in place for diagnostic imaging.
- Medicines were found to be managed securely, however there were issues identified with refrigerator temperatures and the reporting of temperature deviations to pharmacy.
- Staff were aware of how to report safeguarding concerns.
- Protocols were available for use in diagnostic imaging and staff were aware of national guidance from the National Institute of Health and Care Excellence (NICE).
- Staff understood consent and could describe examples where they document consent.
- Staff treated patients with dignity and respect at the services visited. Patients were involved in their care and treatment was discussed with them.
- Patient feedback from the services visited was mostly positive.
- Non-admitted referral to treatment targets in outpatients were being met between December 2014 and November 2015.
- The referral to treatment for incomplete pathway standards were met from April 2015 until November 2015.
- Cancer waiting time targets were met between quarter 3 2013/2014 and quarter 2 2015/2016.
- Staff overall were positive about working in their departments.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff were aware of how to report incidents and staff in outpatients and diagnostics were able to discuss how they had changed their services when serious incidents had been reported.
- Most staff we spoke with understood the duty of candour requirements.
- Areas visited were visibly clean and tidy during our inspection.
- Hand hygiene audit results were carried out monthly.
- Equipment was managed appropriately. Imaging services had a managed equipment service in place with timescales for equipment to be replaced.
- Radiation safety checks were regularly carried out.
- Medicines were managed safely and stored securely.
- Staff we spoke with understood how to report safeguarding concerns and who to contact if required.

However:

- Medication refrigerator temperature deviations in outpatients had not been reported to pharmacy. This was addressed during our inspection.
- Mandatory training completion rates varied amongst the different staff groups

Incidents

- There were no never events in outpatients reported between February 2015 and January 2016. Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers.
- There were no serious incidents reported in outpatients between February 2015 and January 2016.
- Although there had been no never events or serious incidents within outpatient services, there had been some learning and changes made to a patient pathway as a result of a never event in surgical services. There was good evidence of local learning from the incident and a number of changes had been implemented.

Outpatients and diagnostic imaging

- There were 185 incidents in outpatients and diagnostic imaging between February 2015 and January 2016. The most commonly reported category of incidents was treatment and procedure with the second most commonly reported being documentation. 50% of incidents reported to the National Reporting and Learning Service took 90 days or more to report from the time of the incident.
- The trust used an electronic incident reporting system for recording incidents. The system had a prompt to bring duty of candour to the reporter's attention.
- Staff were aware of the need to report incidents via the hospital electronic system. However, not all staff we spoke with had received training on the electronic reporting system which had been in place since April 2015. If staff were unable to log an incident directly, they would report to their line manager or nurse in charge of the department.
- Incidents were an agenda item on the surgical services quality and safety governance meeting and details of an incident that occurred in outpatients was documented on outpatient department team minutes in September 2015.
- Most staff told us they received feedback in relation to incidents within the organisation but did not always receive feedback regarding incidents they reported about delays in patient transport. The electronic reporting system had an option to "feedback to original reporter" which staff told us they were going to try and implement further. We found most staff understood the Duty of Candour and staff were able to explain candour, openness and being honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents 'and provide reasonable support to that person.
- Consultants were involved in investigation of incidents and compiling information for letters to patients under duty of candour.
- Junior doctors felt that they did not receive personal feedback from the incidents they reported. However, they did state that root cause analysis from incidents was fed back at monthly audit meetings and any action plans were discussed.

Diagnostic Imaging

- There were no never events in diagnostic imaging services reported between February 2015 and January 2016.
- The strategic executive information system (STEIS) allows trusts to report serious incidents that have occurred .There was one serious incident reported on the strategic executive information system (STEIS) between February 2015 and January 2016. This incident occurred in diagnostic imaging services and related to the delayed reporting of an x-ray.
- We found that this incident had been investigated and a root cause analysis completed. The serious incident investigation report detailed an action plan and the arrangements for shared learning.
- An incident logged by the diagnostic imaging department on the electronic reporting system required a risk assessment as part of the actions required. We found that this risk assessment had been completed.
- Minutes from the February 2016 radiology risk management team meeting documented that adverse events were an agenda item and discussed at the meeting. The radiology department used the services of a radiation protection advisor from another hospital. Staff told us they went to the radiation protection advisor for advice first on reporting incidents. The radiation protection advisor carried out the first line investigation.
- Information provided by the trust showed that there had been an IR(ME)R incident reportable to the Care Quality Commission in January 2016. We found that this had been reported to the Care Quality Commission. The IR(ME)R reported incident related to a patient identification error.
- Staff we spoke with understood how to report incidents through the electronic reporting system.

Cleanliness, infection control and hygiene

- Areas we visited in outpatients and diagnostics at Airedale and Skipton were visibly clean and tidy.
- We observed staff complying with the hand hygiene policy and "bare below the elbow" practice in clinical areas. Soap dispensers and hand gel were readily available for staff, patients, visitors and the public to use. Dispensers were clean and well stocked. Personal Protective Equipment (PPE) was available and used in outpatients and diagnostics departments when required. They had access to disposable gloves, masks and aprons if required.

Outpatients and diagnostic imaging

- Monthly hand hygiene audits were carried out in outpatients and diagnostic imaging. A trust hand hygiene audit showed that outpatient had a compliance rate of 100% in September 2015, 95% in October 2015 and 93% in November 2015.
- A trust hand hygiene audit in Radiology had a compliance rate of 98% in September 2015, 98% in October 2015 and 98% in November 2015.
- Daily cleaning schedules were in place and signed for when tasks were completed. It was noted that the evening cleaning records were not always completed.
- Waste was appropriately segregated and sharps bins were being used correctly.
- Instruments were cleaned in a central sterilising department and staff reported a good system for collection of used instruments and delivery of clean ones.
- A clean hospitals audit completed in outpatients in December 2015 showed an overall performance of 91.2%. The results from the outpatients audit in August 2015 showed an overall performance of 93.7%.
- We observed staff cleaning toys in the children's play area once they had been used.
- 75% of outpatients and diagnostics nursing staff and 79% of medical staff had up to date training in infection control. The trust's internal target for this training was 80%.

Environment and equipment

- The reception area at Airedale hospital outpatients department had recently undergone a refurbishment. In the new reception area was a café, reception desk and ambulance desk along with a way finder desk and volunteers available to help patients and carers upon arrival to the outpatient department.
- Three electronic check in desks were available for patients. Patients could also check in for their appointment at the main reception desk.
- The reception areas in the audiology and physiotherapy departments were visibly clean and tidy with sufficient seating available.
- We found two sphygmomanometers (blood pressure machines) past their test date. All other equipment checked was labelled and had been tested.
- The audiology department had access to two sound proofed rooms for testing.
- There was easy access to emergency resuscitation equipment in all outpatient areas. These were checked every day to ensure they were in good working order. We looked at resuscitation trolley checklists and found equipment was checked and signed on a daily basis. Drawer locks were in place and seals were broken once a week to check expiry dates of drugs and consumables.
- We saw that there was an emergency grab bag in the Richardson unit to enable staff to commence basic life support until the crash team arrived.
- We observed staff providing training to health care assistants to check the resuscitation trolley in the main outpatients department.
- Outreach clinics were stocked with the equipment needed for the clinics held there.
- Staff told us they had enough equipment to carry out their work.
- A central sterilising department provided clean instruments and collected used instruments for the hysteroscopy and colposcopy clinics.
- Equipment in outreach clinics at Skipton hospital was locked away at the end of clinics.
- The resuscitation trolley at Skipton was regularly checked and stocks obtained from Airedale hospital when required.
- Staff that used the clinic facilities at Skipton highlighted the need for an additional computer for the clinics held on the South side and also the need for a printer. Although staff had highlighted this need, they were unsure what was happening with this request.
- Main outpatients at Airedale had a control of substances hazardous to health (COSHH) folder. Staff told us they were considering making these available electronically through the document system.

Diagnostic Imaging

- All areas visited in diagnostic imaging were tidy and the design was appropriate for the services being delivered.
- Resuscitation trolleys in the imaging service were checked daily.
- A daily check list for oxygen equipment at the waiting bays was in place in the radiology department. This had been checked each day.
- Certain areas in radiology, such as access to the MRI scanners were restricted by doors. Warning signs were also in place to restrict access to the radiological areas.
- Personal Protective Equipment in radiology such as lead aprons, thyroid shields, lead gloves and lead glasses were available.

Outpatients and diagnostic imaging

- A managed equipment service was in place in radiology for scanning equipment. During our inspection they were in the process of introducing a new interventional fluoroscopy suite.
- There were 10 radiation protection supervisors which each covered an area within the department.
- Staff at Airedale wore dosimeters (small badges to measure radiation), however staff at the outreach clinics did not wear these as no risk had been identified at these clinics. . This decision had been made in conjunction with the radiation protection advisor.
- Quality assurance checks on the equipment were carried out by a member of the diagnostic imaging team.
- An equipment maintenance document provided by the trust detailed how often equipment in the department was replaced. Maintenance of equipment was carried out by either medical engineering or external providers.

Medicines

- Medicines in all areas visited were found to be stored securely. Keys to the medicine cupboards in outpatients were in a coded cupboard accessible to staff, all cupboards checked were locked.
- There were locked cupboards in the eye clinic, hysteroscopy suite and ENT for medicines specifically for use in those clinics. Skipton outpatients had safe and secure facilities for medicines kept onsite for outreach clinics.
- Medicine stock rotation was in place in medicine cupboards and medicines checked were in date.
- Medical gases were stored securely and those checked were in date.
- Staff in outpatients ordered medicines as and when they were required
- One of the three main outpatient's refrigerators was outside of its temperature range for three weeks or more. This had been reported to medical engineering, however the out of range refrigerator temperature had not been reported to pharmacy. When this was raised with staff, pharmacy were contacted and advised staff on the action to take with the medicines. Staff also requested pharmacy visit them and train the team on how to reset the refrigerator temperature daily.
- Stock control was in place; in outpatients high cost medicines were ordered by patient name and on the day of clinic to manage stock.
- Patients attending Airedale hospital outpatients for their consultation could collect medicines prescribed at their consultation at the hospital pharmacy.
- Patients at outreach clinics could access their prescriptions at Airedale hospital or a local pharmacy for medicines that needed to start immediately.
- The trust had a process in place for non-urgent medications to be initiated by the patient's GP. Patients were informed that medications initiated by GPs would be available in 3-4 working days and that they should telephone their practice to ensure these were ready for collection before attending.
- Basic analgesia was kept in the outpatients department for patient use if needed. Staff told us that named staff ordered drugs twice a week and undertook a stock check, checking dates of drugs and rotating stock.

Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images.
- An audit of case notes carried in outpatients over one week in 2015 showed 99.9% of notes were available for clinic when required. Staff confirmed that records were usually available in a timely manner for clinic appointments.
- Nursing staff had limited access to electronic records and could only access demographic and appointment details. We observed that this could pose practical problems at Skipton when medical records were lacking pieces of information such as referral letters or test results. However, staff were able to work around this by telephoning administration staff at the main hospital to fax over any information needed.
- We looked at four sets of records at Skipton hospital and found that there was no referral letter in three of them. Although this could be accessed online by the medical staff, nurses could not access these and therefore did not know why the patient was attending the department unless they telephoned the main hospital for the letter to be faxed.
- We saw a lack of information regarding consultations written in paper medical records as consultations were recorded on the electronic recording system and in clinic letters. Staff grade doctors told us that this could cause problems at Bingley clinics where they did not have IT access to the hospital system.

Outpatients and diagnostic imaging

- Records we looked at in outpatients included patient pathway documents that started in outpatients, consent forms, and consultation records.
- Records we looked at in outpatients were signed and stamped with the doctors details.
- There was a safe system in place for transport and storage of records to outreach clinics. Notes were transported in a sealed box with a list of notes sent. Staff at the receiving clinic checked all notes were present as listed and returned them in the same way.
- Notes were stored securely in a locked cupboard at Skipton hospital between clinics and while awaiting transport back to the main hospital site.
- Records were stored securely away and out of sight from waiting patients. Transport and storage of records offsite included a check in and out.
- Records for clinics were transferred to the relevant clinic areas each day. In some areas in outpatients a cabinet was in place for patient notes waiting to be used and a cabinet was in place for patient notes that had been used in clinic. These cabinets were not always locked, however staff assured us they were not left unattended during clinic times.
- Radiology used an electronic system to record patient information. This was password protected.
- Archived records in the radiology department were stored securely in a locked cupboard.

Safeguarding

- Staff we spoke with were aware of their responsibilities to safeguard adults and children and knew who to contact if they were concerned.
- Completion of safeguarding adults and children training varied between the diagnostic imaging staff groups. For example, in radiography 68.4% of staff had completed safeguarding level 2 training against a target of 80%. Radiography were below the 80% completion target for safeguarding adults and safeguarding children level 2 with the lowest completion rate being 66.7% for safeguarding adults. Information on training analysis for diagnostic imaging showed that safeguarding level 3 was not part of the mandatory training for diagnostic imaging staff.
- Safeguarding adults and children training for other staff groups in diagnostic imaging services were mostly above the target of 80%.100% of outpatients nursing staff had up to date training in adult safeguarding and 90% had up to date training in safeguarding children level 2. 100% of outpatients nursing staff had safeguarding children level 3. 90% of additional clinical services staff had safeguarding children level 2.
- 86% of medical staff had up to date training in safeguarding children and 93% had up to date training in adult safeguarding. The trust's internal target for this training was 80%.
- A registered specialist children's nurse (RSCN) based in main outpatients provided good safeguarding support to staff. The outpatients department had introduced extra training and we were told there had been an increase in knowledge of staff on how to respond to 'did not attend' patients.
- Staff in outpatients knew the policy regarding children who did not attend (DNA) appointments and knew who to access for support. The RSCN checked records for any previous DNAs and any other safeguarding concerns. The RSCN or another member of staff attempted to contact parents and establish reason for non-attendance and to give another appointment. GPs were always informed of children DNAs and further appointments sent. Staff made a safeguarding alert where they had heightened concerns.
- Staff in outpatients told us there was good safeguarding support from the hospital safeguarding leads for children and adults.
- In radiology, staff checked for positive identification and checked that the patient was the person on the request card. Staff also checked details on the radiology information system to ensure the right person received the right scan.
- The radiology department used the world health organisation (WHO) safety checklist. This had been adjusted slightly to fit their needs. A safe surgery checklist audit had been completed in December 2015 and showed most compliance levels to be 100% with the lowest compliance level of 97%.

Mandatory training

- Overall training completion in outpatients was at 65.2% against a trust target of 80%. 86% of outpatients nursing staff had up to date mandatory training. The service was at 77% completion versus the 80% target for medical staff completing mandatory training.
- Mandatory training rates in diagnostic imaging showed that a number of staff groups were not achieving the 80% target. For example, Radiology medical staff group

mandatory training completions rates for consent were 77.8% and mandatory training rates for the radiography staff group for dementia awareness were 57.9% against a target of 80%.
- All of the staff we spoke with told us they received on going mandatory training and were aware of how to access this.
- Most of the staff we spoke with told us that their training was up to date.

Assessing and responding to patient risk

- Resuscitation trolleys were available in main outpatients and the radiology department.
- The maxillo-facial team pre-assessed the patients attending for dental extraction, however, if risk factors were identified they were sent to the surgical pre-assessment clinic.
- Consultation rooms and treatment rooms in outpatients had emergency call bells.
- Staff who provided outpatient and radiology services in outreach clinics told us they would call 999 for patient emergencies.
- If there was a medical emergency in any of the outpatients departments the crash team was called.
- 80% of nursing staff in outpatients had up to date basic life support training. 70% of additional clinical services staff in outpatients had up to date basic life support training. The target was 80%.
- We observed staff in phlebotomy and outpatients checking patients identity to ensure correct tests and samples were taken from the correct patients.
- In the event of a children's emergency a dedicated paediatric team attended.

Diagnostic Imaging

- The imaging service had access to a radiation protection advisor from another NHS foundation trust. Staff told us they could contact two people there and that they were responsive and accessible.
- Staff in the imaging service asked patients before arrival at the diagnostic imaging service if they were pregnant. There were also signs within the department providing warnings to women who may be pregnant.
- Patient Group Directions are written instructions that permit the supply or administration of medicines to patients. Patient group directions were in place in radiology. We saw two PGD's and both were in date and signed.
- Staff in the imaging service were able to discuss what action they would take if a patient became unwell whilst under their care. Staff told us they would refer back to the referring doctor or send the patient to accident and emergency if required.
- Justification of scans was in place. The justification process was documented in the employer's procedures for x-rays - Ionising Radiation (Medical Exposure) Regulations 2000 procedure.
- Radiography basic life support training rates were 52.6% for additional clinical service staff and 58.3% for allied health professional staff in radiography. Radiology medical staff basic life support training rates were 66.7% and radiology nursing basic life support training rates were 100%. The target was 80%.

Diagnostic Staffing

- Incident reports were completed in relation to low staffing levels in some areas of diagnostic imaging services. Information provided by the trust detailed the action taken to address these issues, for example providing extra support to staff and providing additional clinics to reduce the requirement to overbook clinics. The information detailed the potential long term plan to include an additional ultrasound machine to increase capacity.
- Radiologist staffing was raised as a challenge in the radiology department. Management were addressing this by recruiting oversees to posts and training radiographers as reporting radiographers. The department had three trained reporting radiographers. Imaging services used an outsourced x-ray service to address any backlog in x-rays and outsourced some x-ray services between 10pm and 8am every day.
- The average use of bank staff in radiology was 7.1% between April 2015 and January 2016.
- The average use of locum staff in radiology was 0.9% between April 2015 and January 2016.
- Management told us there were generally good staffing levels.
- Diagnostic imaging provided sample data for their actual against planned staffing levels. Between January 2016 and March 2016, Plain film planned staffing levels were 12.4 whole time equivalent and the lowest actual staffing level was 11.2.
- The ultrasound planned staffing levels was between 8.4 and 8.7 and between January 2016 and March 2016, the lowest actual staffing level was 6.87 whole time

equivalent. CT and MRI planned staffing levels were between 8.3 and 10.1 whole time equivalents and between January 2016 and March 2016 the lowest actual staffing level was 6.5 whole time equivalent.
- Data provided by the trust showed staffing levels for services rather than staff groups within diagnostic imaging, therefore we were unable to break staffing down by staff group.

Nursing staffing

- Outpatients at Airedale general hospital did not have a fixed staffing model or requirement; senior nursing staff reviewed staffing requirements on a weekly basis. Information provided by the trust detailed staffing concerns were escalated directly to management in outpatients. No staffing acuity tools were in place in outpatients, however the trust told us they would undertake skill mix reviews dependant on service development and need.
- Use of bank staff was low in outpatients. In outpatients, bank usage was an average of 2.9% between April 2015 and January 2016.
- Outpatients had a total vacancy rate of 2.2%.
- The average sickness rate in outpatients was 5.2%.The trust target was 3.6%.
- The average use of bank staff in outpatients between April 2015 and January 2016 was 2.9%.
- There was a registered nurse in charge of each clinic, and a mix of registered nurses and healthcare assistants available to provide care to patients.
- Senior staff we spoke with told us they had appropriate levels of staff on duty in their areas.
- Staffing levels in the outpatient clinics were determined based on the number and type of clinics running each week and the number of patients attending.
- One staff nurse had gone to work on the winter ward. Additional hours were given to clinical support staff and bank staff to cover the vacancy in the department.
- Shortfalls in registered staff and health care assistants due to maternity leave and long-term sickness had been covered by medium term, block booking of bank staff. This meant that the staff covering were able to provide consistency and were competent to fulfil the role required.
- Clinical nurse specialists (CNS) were available in some of the clinics we visited such as; hysteroscopy, colposcopy and urology.
- Phlebotomy staff told us the area felt short staffed at times and that they were busy, however there was good team support, morale was good and staff enjoyed their jobs.
- The trust had a temporary staff induction checklist in place.

Medical staffing

- The individual specialities were responsible for identifying and managing the medical staffing for the outpatients clinics. Medical staff were allocated to individual clinics.
- Middle grade doctors told us that all outpatient services were consultant led and supervision and support was given in clinic.
- The average use of locum medical staff in Ear, Nose and Throat between April 2015 and January 2016 was 91.6%. Information provided by the trust highlighted this was to cover the vacant post in the ear, nose and throat service. Locum medical staff were used in other areas of outpatients when required to meet service demand.
- The trust had a locum medical staff departmental induction checklist in place.

Major incident awareness and training

- An emergency preparedness, resilience and response policy was in place.
- Staff in outpatients were aware of major incident plans and winter surge plans.
- There were contingencies in place for IT breakdown and staff knew what to do if they lost access to electronic records.
- Pathology services had a business continuity plan in place. Radiology had an up to date business continuity plan in place.
- The outpatient department had a business continuity plan for main outpatients, however this was in draft format. Information provided by the trust stated this was under annual review.

Are outpatient and diagnostic imaging services effective?

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Protocols were available in the radiology department on their electronic document system. Examples included a CT abdomen protocol and plain x-ray of the lumbar spine.
- A retrospective audit carried out on the world health organisation safe surgery checklist in imaging services assessed 30 randomly selected between January 2015 and November 2015 showed 100% compliance in most areas of the audit with the lowest being 97% compliance.
- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. This was available on the hospital site and in all outreach centres.
- Staff we spoke with were aware of NICE and other guidance that affected their practice.
- Diagnostic imaging services had completed compliance audits for IR(ME)R and IRR99. A radiation protection advisors report was also completed in 2014/2015.
- PAUSED is a checklist used in clinical imaging departments prior to a scan. The 'PAUSED' checklist was in place in diagnostic imaging. This had been sent to all staff.
- Standard operating procedures were available in all hospital clinics and outreach clinics.
- A diagnostic reference level audit had been completed in 2015 and an action plan to address the findings was in place dated May 2016.
- Imaging services had a non-ionising radiation protection 2014/2015 annual report carried out by radiation physics services at another hospital. The report stated that the trust complied with the regulations and that the radiation protection advisor had been consulted as necessary. There were no recommendations from the report.
- Imaging services had an audit carried out in 2015 which checked compliance with Ionising radiations regulations 1999 (IRR99) and Ionising radiation (medical exposure) regulations 2000 (IRMER). The audit was completed across all sites of the trust between May 2015 and August 2015. The audit found that compliance with IRR99 and IR(ME)R was good across most of Airedale foundation trust, however there were some areas that required further action to fully comply with the legislation. An IR(ME)R audit action plan was in place dated 2015/2016 and highlighted when the action should be completed by and indicated whether it was complete or outstanding. The trust provided information confirming most audit actions were complete and there was one outstanding action.
- Diagnostic imaging services outsourced some reporting services between 10pm and 8am and outsourced, if required, to address any back log of work. Information provided by the trust detailed that diagnostic imaging received quarterly reports detailing the number and percentage of discrepancies.
- Information provided by the trust detailed that most imaging is quality checked at the time of reporting by a radiologist or reporting radiographer.

Pain relief

- Pain relief medication was not generally administered in the outpatients department, but the doctors in clinic could prescribe medication for any patient needing pain relief.
- A small stock of pain relief was kept in the outpatient department for patient use, when prescribed.
- The departments stocked local and topical anaesthetics for use during interventions.
- Post-operative patients were given the dental outpatient number to contact if they had any concerns. Patients who were unable to control pain were given advice over the phone and could be brought into the clinic if needed. Patients would be seen as extras at the end of clinic if needed.

Nutrition and hydration

- A café and shop were available where people could purchase drink and food items.
- Staff were able to provide drinks to patients if required.

Patient outcomes

- Between September 2014 and August 2015 the trust's new to follow up rate was in line with the England average. The trust new to follow up rate averaged at 2.5 for this period.
- Between August 2015 and November 2015 between 3% and 4% of all clinics each month were cancelled within six weeks of the appointment date and between 4% and

7% of clinics more than six weeks from the appointment date were cancelled each month. The main reasons for cancellation of clinics were consultants booking study leave or annual leave and clinician sickness.

- Clinic consultations and outcomes were dictated into computer software which were immediately available to the medical secretaries. Medical secretaries told us that letters to GPs were usually typed within 2-3 days of clinics.
- Colposcopy carried out a 'did not attend' and 'follow up's audit between January and March 2015. The audit considered 'did not attend' rates and 'did not attend' outcomes.
- Data provided by the trust for quality indicators in pathology for turnaround times were 90% and above between Quarter 1 and 4. The target for a green rating was more than 83%.

Diagnostic Imaging

- A DEXA scan patient satisfaction survey carried out in imaging services in 2015 showed that the average scores were mostly above four and mostly positive. The survey used a score system where zero was disagree and five was agree. 50 surveys were completed.
- A patient satisfaction survey carried out in May 2015 at Keighley health centre for imaging services showed that the average scores were mostly above 4 and mostly positive. The survey used a score system where zero was disagree and 5 was agree. 50 surveys were completed.
- A patient satisfaction survey carried out for imaging services at Skipton hospital showed that the average scores were mostly above 4 and mostly positive. The survey used a score system where zero was disagree and 5 was agree. 50 surveys were completed.

Competent staff

- Data provided by the trust show that the outpatient nursing appraisal rates between April 2015 and March 2016 was 85.7%.
- Staff told us they are encouraged to develop and complete further training in outpatients and diagnostic imaging.
- Variable staff performance was managed through a poor performance policy. Advice from human resources was also sought if required.
- There was no system in place in outpatients for regular clinical supervision in outpatients. Staff told us they felt there was always someone to talk to if required.
- Physiotherapy outpatient's staff told us they had regular clinical supervision.
- Staff had received an induction and new or newly qualified staff in outpatients were allocated a named mentor.
- Support and development needs of specialist nurses were also met by attendance at national network meetings and conferences. Some staff had been supported to attend a conference and had brought ideas back for developing the department at Airedale.
- Staff we spoke with felt that appraisals were worthwhile and facilitated personal development. Many staff we spoke with confirmed that they had received support from the trust to undergo further training and professional qualifications.
- Some staff in outpatients had undertaken further training, such as dental nurse training to support service development and to provide a pathway approach to patients undergoing dental extraction.
- There was a mentorship process in place for newly qualified staff in outpatients.
- Nurses within a number of areas in outpatients had been able to develop as advanced nurse practitioners. For example, urology and gynaecology.
- Middle grade doctors told us that they were able to provide some clinics when they had reached a certain level of competence.
- Agency administration staff in outpatients did not always complete the induction training for outpatient administration staff.

Diagnostic Imaging

- Diagnostic imaging services had an appraisal completion rate of 89% between April 2015 and December 2015.

Outpatients and diagnostic imaging

- Staff told us that appraisals were carried out annually, however areas such as CT and MRI were not currently up to date with annual appraisals.
- Staff told us that learning needs were identified at annual appraisals. The radiology department were looking at appointing a learning representative.
- In diagnostic imaging services, staff told us their induction was good and they were provided with a mentor during their induction.
- Diagnostic imaging services had 10 trained radiation protection supervisors.
- In diagnostic imaging a number of staff we spoke with had completed further training and development.
- Information system training files were not always signed in diagnostic imaging services, however staff assured us staff working on IT systems had been trained.

Multidisciplinary working

- A service level agreement was in place between Airedale hospital and another teaching hospital for the provision of radiation physics support for Airedale NHS Foundation Trust.
- Diagnostic imaging staff told us they attended multidisciplinary team meetings and that there were good links with medical teams and the accident and emergency department.
- Diagnostic imaging services management worked with commissioners and sat on a group which worked on pathways and benefits to patients.
- There was evidence of multidisciplinary team (MDT) working in the outpatients. For example, MDT room virtual clinics with consultants at other hospitals.
- Specialist nurses ran clinics alongside consultant-led clinics for hysteroscopies.
- A range of clinical and non-clinical staff worked within the outpatients department. Staff were observed working in partnership with people from other teams and disciplines, including radiographers, nurses, booking staff and consultants.
- The maxillary-facial team from Airedale had worked with visiting consultants from another hospital and the theatre team within Airedale trust to develop a new pathway approach. The different teams had worked together and adopted a pathway approach for patients which meant that patients were cared for by the same group of staff from first outpatient attendance to theatre and at follow up.Nursing staff at Airedale were included in the governance meetings at the other hospital.

Seven-day services

- Most outpatient services were provided during the day, Monday to Friday.
- Outpatient nursing staff told us that they had previously provided weekend clinics in times of increased demand. A recent Saturday clinic in maxillo-facial saw 64 patients to reduce the waiting list and stop breaches from occurring, this also happened in other specialities if required.
- There was a once weekly urology and neurology evening clinic at Airedale general hospitals outpatients.
- Gastroenterology, urology and cardiology had all provided Saturday or evening clinics when necessary to meet demand.
- Most diagnostic imaging services were offered between Monday and Friday. Weekend clinics were added if required and the emergency department had 24 hour, 7 days a week diagnostic imaging services.

Access to information

- Staff had access to information relating to policies, procedures, NICE guidance and e-learning via the trust intranet.
- Medical staff were able to access patient information, such as imaging records and reports, medical records and physiotherapy records through electronic records from the main hospital site and from Skipton hospital where they held outreach clinics.
- Patients were given a pro-forma sheet with details of their consultation and this was used to book any follow up appointment at the main outpatient reception.
- Secretaries generated typed letters of consultations for GPs within 2-3 working days.

Diagnostic Imaging:

- Electronic access to diagnostic results was available through two information systems. A picture archive

communication system was used to store and share images and patient reports. An information system was also in use to store electronic patient records and referral letters.

- The diagnostic imaging service provided timely access to diagnostic imaging results. Staff told us ultrasound results were available same day and urgent results were made available on the same day.
- Patient information leaflets were available for different exams and were sent out in appointment letters.
- The diagnostic imaging service was part of the image exchange portal which allowed the service to check previously scanned images if required or to potentially decrease the need for the patient to have another scan. This data was kept for 90 days. Staff told us they were looking at ways of collaborating with regional colleagues regarding scanned images.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A trust mental capacity act policy was in place and included details on the deprivation of liberty standards.
- A consent to care and treatment policy was also in place. This had a review date of January 2016.
- We saw good examples of separate consent forms for adults, children, and adults who were unable to consent to treatment.
- There was some procedure specific consent forms, which clearly stated potential complications following certain procedures, consent forms, also advised the patient regarding tissue sample analysis and retention. There were separate consent forms in use for patients who lacked capacity.
- If interpreters were required to enable informed consent, they were also signatories on the consent form.
- Verbal consent was taken for procedures such as administration of eye drops, blood sampling, ECGs, weights and blood pressure recordings.
- Staff told us they would request support from the medical staff to assist in assessing a patient's mental capacity.

Diagnostic Imaging

- Staff told us they sought written consent for any interventional procedures in the radiology department.
- Implied consent was accepted as appropriate for patients undergoing x-rays and non-invasive scans.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff treated patients and carers with compassion, dignity and respect at all areas visited.
- Staff responded to patients needs in a timely manner and took into account the different needs of patients.
- Staff communicated with patients in a clear way and provided information and advice to patients as needed.
- Patients we spoke to were positive about the service provided in outpatients and diagnostics.
- Patients and carers were involved in their treatment and treatment was discussed with patients.
- Quiet rooms were available for patients, carers and families if required.

Compassionate care

- Friends and family test data between December 2014 and November 2015 show that the trust have had higher recommendation scores than the national average. 97% of respondents in November 2015 would recommend outpatient services.
- Staff told us they would apologise to patients if their outpatient appointment was running over 30 minutes late.
- In the radiology department there was a sign before the reception desk asking patients to 'wait here'; this had been placed here to ensure patients at the reception area could speak without being overheard.
- Privacy curtains were available in all clinic rooms visited to ensure privacy and dignity of patients.
- Confidentiality was respected by staff at the areas visited. We observed staff checking a patient's date of birth and name upon arrival to the clinic area.
- Patients were treated with dignity and respect in areas visited.
- We observed staff were friendly and welcoming towards patients entering the department.

Outpatients and diagnostic imaging

- We observed that staff were courteous when caring for patients and were seen responding to patient's individual needs in a timely manner.
- Care was provided in individual consulting rooms; we noted that doors were shut to ensure privacy. There were curtained bed areas in clinic rooms and doors had "in use" signs.
- Some clinics, such as gynaecology and urology, routinely had a chaperone for patients.
- Patients could ask for a chaperone for other clinics where this was not routine and there were posters advertising to patients that they could ask for a chaperone.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a clear way and checked they understood their care.
- Patients we spoke with told us that staff were polite, friendly and helpful.
- In urology staff had contact cards which were given to patients which provided contact details if they needed to contact the service. A number of patients we spoke with had been provided with contact details of the clinic if they had concerns or questions.
- Patient's told us they were fully involved in their treatment and treatment was discussed with them. Patient's felt able to ask questions and discuss their treatment with staff.

Emotional support

- A quiet room was available in the radiology department for patients to use for private conversations with staff.
- Staff in diagnostic imaging services were able to describe situations where they had provided additional support for patients who may require support attending the department.
- The specialist nurses were available to support patients when receiving bad news and to offer follow up support and advice. Staff took patients to a quiet room for privacy when they were distressed or had received bad news.
- A number of information boards were visible in the outpatient departments providing patients and carers with information on support and services available. For example, there was a patient advice and liaison (PALS) board and a caring for carer's board.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Facilities and the environment was suitable meet the needs of people.
- Staff were considering ways to better the experience of patients in outpatients.
- Telemedicine services had been implemented and the trust were looking at expanding this to provide further services to patients through the use of technology.
- Non-admitted referral to treat targets in outpatients were being met between December 2014 and November 2015.
- The referral to treat for incomplete pathway standards were met from April 2015 until November 2015.
- Cancer waiting time targets were met between quarter 3 2013/2014 and quarter 2 2015/2016.
- Interpreter services were in place and were provided by the trust. Staff told us these services were responsive.
- There were a low number of complaints for outpatients between December 2014 and December 2015.

However,

- Diagnostic imaging did not always meet their report turnaround targets of 80%.

Service planning and delivery to meet the needs of local people

- Areas visited in outpatients and diagnostic services were appropriate. All areas had toilets and disabled toilets available and seating was adequate in all areas visited.
- A café was available in the main outpatient area. Staff were able to provide drinks to patients in the different clinic waiting areas if required.
- Changing room facilities were available in the radiology department.
- A children's play area was available in outpatients and toys were available in waiting areas in the radiology department.
- A new sign posting system had been implemented throughout the hospital trust, outpatient and diagnostic service areas were sign posted.

Outpatients and diagnostic imaging

- A trial in outpatients had been carried out to assess the use of pagers to allow patients to leave the waiting area and be contacted when their appointment was due in clinic. This had been successful and the trust had ordered more pagers to expand the service to patients.
- The trust had implemented telemedicine and were expanding this service to different patient groups.
- Outreach clinics had been implemented in some areas to meet demand.
- Some patients we spoke with raised concerns regarding the parking not being sufficient. Outpatient management told us they were looking at ways of addressing the parking issues.

Access and flow

- There were 235,687 outpatient attendances between September 2014 and August 2015.
- Between September 2014 and August 2015 the trust's Did Not Attend (DNA) rate was between 5% and 7%.Staff told us they had implemented text reminders to patients to help address DNA rates and had a call reminder service in use which allowed service users to cancel, change or accept the appointment. Staff were considering ways of making the call reminder service more personalised and effective.
- Between December 2014 and November 2015 the trust met the 95% non-admitted referral to treatment (RTT) standard that was in place until June 2015.
- For incomplete pathways, the trust met the 92% RTT standard from April 2015 to November 2015.
- The trust met all of the following cancer targets between Quarter 3 2013/14 and Quarter 2 2015/16:
- More than 95% of people were seen by a specialist within two weeks for an urgent GP referral. The threshold for this target was 93%.
- More than 96% of people waited less than 31 days from diagnosis to first definitive treatment.
- More than 85% of people waited less than 62 days from urgent GP referral to first definitive treatment.
- Data provided by the trust showed that during October 2015, the 62 day cancer waiting time target was not met. The trust were at 83.8% for the 62 day cancer waiting times against a target of 85%. The trust were at 83.8% for the 62 day screening against a target of 90%.
- Data provided by the trust showed that the 62 day cancer waiting time target for all services overall was 87.5% or above between November 2015 and April 2016, however Gynaecology waiting time indicators were not met between January 2016 and April 2016. In April 2016, gynaecology waiting time performance was 66.7%. Capacity for outpatient appointments was highlighted as a challenge by staff. Staff told us they were addressing this by increasing use of ambulatory care and further implementing rapid access clinics.
- The majority of patients accessed outpatient appointments through GP referral and by using choose and book. GPs faxed urgent referrals to appointments.
- Consultants screened all outpatient referrals to ensure they were to the most appropriate person to see the patient and to determine urgency. Patients would then be allocated an appointment in the most appropriate clinic.
- If a consultant judged that the referral was inappropriate then the booking would be rejected and the patient's GP was advised to refer them to an alternative service. If the patient would benefit from seeing a different consultant within the same speciality then the referral was redirected internally.
- There was a fast track system for neurology and cardiology patients who needed an urgent appointment. Cardiology patients could see a consultant within 24 hours if needed, other patients who were less urgent were seen within two weeks.
- Consultants from other specialities kept clinic slots for urgent patients or would see them at the end of a clinic if necessary.
- Staff in appointments told us they would negotiate additional clinics with consultants and outpatient managers where needed.
- A number of services offered outreach clinics at Skipton hospital and some GP practices.
- A number of one stop clinics had been implemented such as urology, hysteroscopy and colposcopy.
- A phlebotomy service was also offered each morning, Monday to Friday.
- In November 2015, 3% of patient appointments were cancelled within 6 weeks of the appointment and 4% of patient appointments were cancelled over 6 weeks of the appointment.
- Information provided by the trust show that 15% of patients each week wait over 30 minutes to see a clinician. Less than 5% of patients wait longer than 30 minutes in audiology.
- Data provided by the trust for pathology showed their accident and emergency quality indicators were

between 85% and 90% between January 2016 and March 2016. Routine test turnaround times were mostly above the 90% target except for March 2016 which was 85% to 90% achieved.

Diagnostic Imaging:

- Staff told us the DNA rate in diagnostic imaging was usually around 3.5%.
- Between June 2014 and November 2015 the percentage of patients waiting less than 6 weeks for diagnostic tests was better than the England average. Only between March 2015 and June 2015 were there any patients who were waiting more than 6 weeks.
- Waiting times on arrival to the radiology department in November 2015 show that 100% of patients waiting for CT, DEXA, Fluoroscopy, MRI and Radiography were seen within 30 minutes. In ultrasound 83.3% were seen in less than 30 minutes, 4.2% seen in 31-45 minutes and 12.5% seen in 46 – 60 minutes.
- Information provided by the trust, where they selected a random week between July 2015 and November 2015, showed that radiology report turnaround times were 85% of all exams reported within two working days and 95% of GP exams reported within two working days during week 1. Data from week 5 of the information provided show that 79% of all exams were reported within two working days and 87% of GP exams were reported within 2 working days. Data provided by the trust over the five week sample showed they were mostly above their targets of 80%.
- Information provided by the trust on patients waiting for appointments in November 2015 for imaging services, physiological measurement and endoscopy showed that no patients were waiting over 6 weeks for an appointment.
- Data provided by the trust showed that the percentage of exams reported over 42 days breached the 5% target between October 2015 and December 2015 in ultrasound.
- Data provided by the trust showed that there were no breaches to the CT exam reporting target between October 2015 and December 2015. Breaches of the MRI reporting target varied between October 2015 and December 2015.
- Inpatient reportable targets for inpatient scans within 48 hours were mostly above the 80% target between September 2015 and December 2015.
- Inpatient reportable targets for inpatient scans within 24 hours were above the 80% target between September 2015 and December 2015 for CT scans and ultrasound was mostly in line with the 80% target except for December 2015 where it was below 60%.

Meeting people's individual needs

- Interpreting services were available in outpatients and diagnostics. The trust had an internal translation service which staff told us was responsive and available when required.
- We saw a range of patient information leaflets were available across the departments.
- Disabled changing rooms were available in radiology services for patients.
- Audiology services had a hearing loop in place for patients to use.
- Staff were responsive to patient's needs and responded to patient concerns.
- Staff were able to describe how they cared for patients with memory impairments and learning disabilities. They gave practical examples of how these patients' needs could be accommodated in the departments and who they could contact for further advice and support. Staff told us how they involved family and carers as much as possible with the care of patients living with dementia and learning disabilities to alleviate as much anxiety and distress for the patient as possible.
- We saw evidence of the 'butterfly' dementia scheme in use. The butterfly scheme provides a system to alert staff that there may be additional support needs.
- When a referral from a GP was received with any information regarding language needs, learning disability, dementia or physical needs such as whether patients needed a hoist, booking staff entered this onto the electronic records so this was available to staff.
- Outpatient areas supported the use of loop system for people with hearing impairment.
- Bariatric chairs were available in the hospital outpatient areas but not in the outreach clinics.
- The radiology department had changing rooms available for patients which were sufficient in size, clean and tidy.
- Volunteers were available at a way finder desk in outpatient's reception to assist patients getting to their clinic.

- We saw staff inform patients if clinics were running late. Staff apologised and explained why appointments were delayed.
- Hoists were available in the Airedale clinic area and staff knew where they could access a hoist from, on the Skipton site.
- Areas of the outpatient department had trialled the use of pagers for patients who were likely to have to wait for their appointment. The pagers meant that patients could go for a meal or drink in the hospital café and be paged when they could return to the x-ray department for their scan. The trial had proved successful and had 40 devices on order to improve the experience of patients.

Learning from complaints and concerns

- There were a low number of complaints for outpatients and diagnostic services. There were eight complaints aligned with outpatients between December 2014 and December 2015.
- Patient Advice and Liaison Service information was on display in clinics in outpatients and diagnostics.
- Patients could feedback complaints and concerns in a number of ways, including formally, via PALS, and by completing patient feedback cards. Posters were displayed to explain how to raise concerns.
- All the staff we spoke with showed a willingness to pro-actively respond to patient feedback to try to resolve concerns as soon as they became aware of them. Staff were aware of PALS and the formal complaint process if they were unable to resolve a patient's concerns.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well led as good because:

- Plans were in place to develop the services offered by outpatients and diagnostics.
- Risk registers were in place for outpatients and diagnostics and included outcome details.
- Staff felt supported and staff had developed in their roles.
- Staff were positive about working in their departments and were focused on patient care and experience.

Vision and strategy for this service

- An annual plan detailed the right care vision which included details on outpatients through to 2019/2020. Examples of the key areas outlined in the plan were evening and Saturday clinics, community clinics and improved use of technology.
- Pathology had documented key strategy points to support the right care vision. An example being further streamlining of electronic requesting and reporting. The supporting document detailed a proposed joint venture and detailed the potential benefits of an integrated pathology service such as improved patient care and experience.
- The diagnostic imaging service had a strategy to support the right care vision which included points on cross partnership working, digital care and inpatient flow for example.
- Staff we spoke with understood the "right care" vision.
- Management were able to discuss the development of outpatient's services and could discuss a range of roles and skill mix within outpatients to meet demand.

Governance, risk management and quality measurement

- Outpatients were part of the surgical division and attended the surgical service divisional group meetings.
- The outpatient risk register was included within the surgical services risk register. Action plan and controls in place sections were documented.
- A risk register was in place for the radiology department. Risks were documented on this register and details of the actions required were documented. Risks identified during the inspection such as radiologist staffing levels were highlighted on the department risk register.
- The diagnostics general manager was the governance lead for diagnostics. We were told each team had a governance meeting each month. This was then fed into the diagnostics management meetings which fed into the delivery assurance groups meetings to ensure governance information was escalated when required. We were told that any risk scoring above nine would go onto the corporate risk register.
- Diagnostics and therapies had a clinical audit programme in place dated December 2015.

- Audits were in place for IR(ME)R regulations, non-ionising radiation protection (NIRP) reports and radiation protection advisors reports were carried out. Action plans were in place for the IR(ME)R audit where non-compliance was found.
- Information provided by the trust detailed that diagnostic imaging received quarterly reports detailing the number and percentage of discrepancies for outsourced x-ray services. Pathology had a number of quality indicators in place to monitor turnaround times.
- Outpatient management were able to discuss where there were capacity pressures in outpatients. Staff told us appointment capacity issues were escalated through the appropriate channels. Information provided by the trust highlighted that the trust were focusing on areas where the referral to treat targets were not being achieved.

Leadership of service

- Outpatients were part of the surgical division management structure. The outpatient service was managed locally, management from the outpatient service reported to the surgical directorate senior management.
- Diagnostics was managed by heads of service in their respective areas, such as radiology and pathology.
- Staff we spoke with in diagnostic imaging services were positive about the support from management.
- Staff we spoke with overall were positive about the management of outpatient services. Staff felt that the present management structure was clear and supportive at local level.
- There was inconsistency with local team meetings throughout the outpatients and diagnostics departments, some staff had regular meetings whereas other staff groups did not hold regular team meetings.
- We found that managers encouraged staff to participate in on-going learning and professional development and were open to ideas and suggestions for improvement. We spoke with staff that had benefitted from investment in their development.
- Staff told us there were good flexible working arrangements in place, teamwork was good and they felt listened to.
- Staff we spoke with reported that the senior executive team communicated well and that relevant information was disseminated to staff via email and bulletins.

Culture within the service

- Staff we spoke with were positive about working in their departments. Staff described a culture of support and team work in outpatients and diagnostics. Morale was raised as an issue in some areas of diagnostic imaging services, however staff told us management were addressing these issues.
- Staff we spoke with were proud of their service and the trust. Staff we spoke with were positive about their role and the support in place for staff.
- Staff were motivated and centred on providing a good patient experience.
- The majority of staff we spoke with in outpatients had worked at the trust for many years and enjoyed their role. They felt the trust offered good opportunities for personal and career development, there was good teamwork and they were well supported.
- There was a well-established culture of learning and development and there were many examples which demonstrated valuing staff, where staff had been given opportunities to develop, change role or be promoted.
- Staff described the culture as open and honest and they were encouraged to report incidents and learn when things went wrong.

Public engagement

- Feedback was sought from patients and the public during the refurbishment of the outpatient department. A stall was set up to allow patients and the public to speak with staff about the changes.
- The outpatient areas employed volunteers who acted as way finders to help patients with check-in and to signpost them to various departments. Volunteers had raised money for the refurbishment of the main entrance coffee shop and phlebotomy waiting area and also to purchase some equipment for the department.
- We saw that efforts had been made to tailor notice boards to provide information to the public on health issues. There was a food and nutrition week display in the main corridor.
- Men's and women's health boards were displayed and included information about carer support.
- We saw 'Your experience counts' posters and comments boxes for patients to leave comments and suggestions.

There were 'You said we did posters in some areas and along the windows through the main hospital corridor. There were posters inviting patients to get involved in improving services, displayed in the Richardson unit.

Staff engagement

- Staff in diagnostics told us that the team had regular meetings.
- There were no set regular team meetings in main outpatients. Staff in outpatients told us they received weekly team briefs and updates via email.
- The services we inspected were supportive of staff development.
- Nursing staff were aware of revalidation and that road shows were going to be held to provide information to them regarding meeting the requirements of the NMC for revalidation.
- Staff told us they were well informed about management changes within the department.
- Staff described being listened to and told us that their ideas for service improvements were taken on board. Where ideas were found to be feasible, staff were supported to implement service improvements or change ways of working.
- Staff told us they had a suggestion box in the department and ideas were read out and considered at team meetings. Staff said they could also raise concerns anonymously in this way if they wished.
- Staff told us they enjoyed working for the organisation.
- Staff told us of how they had been supported with development and career progression.

Innovation, improvement and sustainability

- Staff told us telemedicine had been introduced and were considering ideas for the future for providing outpatient reviews through telemedicine. E- Consults and telephone consults and been implemented for some groups of patients. Staff discussed the idea of further developing and increasing the use of telemedicine.
- The maxillo-facial clinic had developed a new pathway in response to an incident and worked with other areas of the trust to develop this.

Outstanding practice and areas for improvement

Outstanding practice

- 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 hospital MUST take to improve

Action the hospital 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 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.
- 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.

Outstanding practice and areas for improvement

- A multi-disciplinary clinical ward rounds within Critical Care must take place every day, in accordance with national guidance, to share information and carry out timely interventions.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

Urgent and emergency care

- The trust should review why the number of patients leaving without being seen is higher than national average, and take action to reduce this number.
- The trust should improve ambulance turnaround times.
- The trust should ensure all MAJAX equipment is checked regularly and is in date.
- The trust should review compliance with the infection prevention guidelines when administrating intravenous drugs.
- The trust should review the recording of the cleaning of the children's area including the toys.

Medical care

- The trust should consider performing a regular service specific mortality review and ensure actions are taken as a result of the review.
- The trust should display the full safety thermometer information to patients, visitors and staff.
- The trust should review the environment and capacity in the haematology and oncology day unit.

Surgery

- The trust should review ward rounds on the surgical areas to ensure patients are appropriately reviewed by senior doctors.
- The trust should ensure staff have access to up to date policies and guidelines based on best practice.
- The trust should ensure patients receive timely pain relief.

Critical care

- The trust should review implementation of the Guidelines for the Provision of Intensive Care Services (PICS) 2015 guidance.
- The trust should ensure staff have supervision and appraisals as agreed by the trust to enable staff carry out their duties which they are employed to perform.

Maternity and gynaecology

- The trust should consider developing a maternity and gynaecology strategy to give direction and achievable objectives to the department.
- The trust should consider safety briefings as part of daily communication with staff in maternity services.
- The trust should review the use of the 'scrub' midwife on the labour ward and staffing establishment in maternity using a standardised acuity tool.
- The trust should consider submitting and displaying data to the maternity safety thermometer.
- The trust should audit the compliance of MEOWS charts on the labour ward.
- The trust should have systems in place to ensure investigations, including root cause analyses, are completed in a timely manner and in line with national guidance.

Children and young people

- The trust should review the environment in the child development centre.
- The trust should review access and monitoring of safeguarding supervision.
- The trust should review the provision of food to children so each person's nutritional needs are met.

End of life care

- The trust should ensure that 'do not attempt cardiopulmonary resuscitation' decisions are always made in line with national guidance and legislation
- The trust should review the route families take to the mortuary and work to improve the environment in the viewing room.
- The trust should review the mode of transport used for transferring deceased babies and small infants to mortuary
- The trust should review infection prevention and control measures within the mortuary
- The trust should review the staffing levels for specialist palliative care team doctors
- The trust should review resilience around staffing in the mortuary.
- The trust should work to improve recorded preferred place of death
- The trust should consider auditing the responsiveness of referrals to SPCT

Outstanding practice and areas for improvement

- The trust should improve engagement with Black and Minority Ethnic (BME) communities, to identify if the trust is meeting the needs of this group of patients at end of life

Outpatients and diagnostics

- The trust should review shared learning from incidents and complaints regularly and to all groups of staff.
- The trust should review the use of clinical supervision in the outpatient department.
- The trust should continue to address cancer waiting time targets.
- Outpatient services should consider regular team meetings.

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%.

This section is primarily information for the provider

Requirement notices

At least 50% of nursing staff should have post registration training in critical care nursing; this had been completed by 38% of nursing staff.

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 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.

This section is primarily information for the provider

Requirement notices

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.

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

This section is primarily information for the provider

Requirement notices

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
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.

This section is primarily information for the provider

Requirement notices

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