Airedale NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

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

We rated Airedale NHS Foundation Trust as requires improvement overall.

At this inspection we found:

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

Summary of findings

- There was inconsistency in the application of systems, processes and standard operating procedures, including the WHO five steps to safer surgery, to keep people safe, particularly within theatres.
- The environment in the Dales Unit and Haematology Oncology Day Unit required addressing to ensure they met patient need and national guidance.
- The trust was to review the WRES work plan in line with the published 2017 guidance to ensure actions addressed the issues identified in the 2016 NHS Staff Survey and the 2017 WRES data analysis.

However:

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

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

Trust-wide

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

Urgent and emergency care services

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

Medical care services

- Ensure the current capacity and demand issues faced by the Haematology Oncology Day Unit are reviewed and ensure the clinical environment where treatment is provided is fit for purpose in delivering patient care and treatment.
- Ensure safe nurse staffing levels and safe nurse staffing skill mix is maintained across all clinical areas at all times.
- Ensure the 'bleep rota' used to support nurse staffing escalation processes is revisited and ensure all escalation processes are effective in managing nurse staffing issues.
- Ensure all staff follow the standard operating procedure covering the opening and closing of extra capacity beds/wards.

Summary of findings

- Ensure all patients received onto the cardiac catheter lab are handed over to a member of staff immediately on arrival and are provided with a mechanism to contact staff in the event of a care need or emergency.

Surgery services

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

Critical care

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

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Background to Airedale NHS Foundation Trust

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

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

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

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

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

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

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, retired Medical Director

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

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

How we carried out this inspection

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

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

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

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

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

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

Summary of findings

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

What people who use the trust's services say

- The trust's Friends and Family Test performance has been better than the England average from August 2016 to February 2017. On average, 96.8% of people would recommend the trust compared to the England average of 95.4%.
- The results of the annual CQC Inpatient Survey 2015 showed the trust performed about the same as other trusts for all 12 questions.
- The national maternity survey from 2015 showed the results Airedale NHS Foundation Trust were better when compared to other trusts for labour and birth and about the same for staff during labour and birth and care in hospital after birth.
- The trust performed worse than the National average in all areas of the Patient Led Assessments of the Care Environment (PLACE) 2016 with the exception of organisation food which scored 88% against the National average of 87%.

Facts and data about this trust

- From January 2016 to December 2016 the trust had 57, 656 A&E attendances, 235,967 outpatient appointments, 53,370 inpatient admissions, 2,112 births, and 683 deaths.
- The catchment area of the trust covers people in Bradford, Craven and Pendle. The health of the people across these locations varied compared with the England average. In Bradford and Pendle, deprivation is lower than average and in Craven it is higher than the England average. The number of children living in low income families is worse than the England average for Bradford and Pendle while Craven is better than the England average. Life expectancy for both men and women is worse than the England average for Bradford and Pendle, while Craven is better for both men and women.
- Mortality data for the trust showed that from October 2015 to September 2016, the hospital standardised mortality ratio (HSMR) was within the expected range of 91.50 compared to an England average of 100. The summary hospital-level mortality indicator (SHMI) was within the expected range of 0.93 compared to an England average of 1.0.
- In the NHS Staff Survey (2016), the trust performed better than other trusts in 11 questions, about the same as other trusts in 10 questions and worse than other trusts in 11 questions. Overall staff engagement ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.81 was average when compared with trusts of a similar type.
- The trust had a deficit of £998k for 2015/16. This was £208k better than anticipated and when the total income from activity was taken into consideration, the trust had a cash balance of £11.6 million at the close of the financial year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We carried out this inspection because, when we inspected the service in March 2016, we rated safe as 'requires improvement.' We asked the provider to make improvements following that inspection. At this inspection, we rated safe as requires improvement because: • Although safeguarding policies were in place and staff were familiar with these, when we reviewed two serious incidents, the safeguarding policies had not been consistently followed. • There had been improvements made to nurse staffing, however, the actual number of staff on duty were often lower than the planned numbers especially on some wards in surgery and medicine. There was also a shortage of specially trained children's nurses within ED. • Medicines management had improved since our previous inspection, however we identified examples of outstanding actions had not been completed or interventions had not been followed up following medicines reconciliation. • There was inconsistency in the application of systems, processes and standard operating procedures, including the WHO five steps to safer surgery, to keep people safe, particularly within theatres. However: • Staffing levels in critical care had improved and were mostly in line with national guidance. • Improvements had been made to the safety and communication issues identified during our previous inspection for patients being monitored by telemetry (remote cardiac monitoring) and improvements in the use of NEWS (National Early Warning Score) or PAWS (Paediatric Advance Warning Score) to monitor patients had been sustained. **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 was aware of its obligations in relation to the duty of candour requirements • The trust's serious incident policy and being open policy incorporated guidance for staff on implementation of the duty.	**Requires improvement** 

- There were systems in place to monitor the adherence to the duty through the trust's quality and safety team.
- The trust's online incident reporting form included prompts for the duty of candour at three steps of the process.
- Different levels of training had been provided to staff. An overview of the key steps to the duty of candour was provided at mandatory training for all staff, lead investigator training included the principles of the duty of candour and there was a specialist session on the duty of candour available for staff.
- Most staff were aware of the duty of candour requirements and spoke about being open and honest with patients and their relatives.
- We reviewed eight serious incident investigation reports and found evidence the duty of candour had been applied.

Safeguarding

- The interim director of nursing was the executive lead for safeguarding adults and children within the trust.
- There was the required personnel in post within the trust; a named nurse for safeguarding adults, a named nurse for safeguarding children, a named midwife and a named doctor for safeguarding. This was supported by operational safeguarding groups for children, adults and the emergency department. There was also a safeguarding children nurse specialist, a paediatric liaison nurse in the emergency department and administration support for the safeguarding team.
- There was a trust-wide adults and children's strategic safeguarding group, which included community staff, and was chaired by the interim director of nursing. This was supported by operational safeguarding groups for children, adults and the emergency department. The adults and children's strategic safeguarding group reported to the quality and safety operational group, a sub-committee of the board.
- The trust had a safeguarding children policy in place. The safeguarding children & young people policy, dated September 2016, included a paragraph on female genital mutilation (FGM) and there was a hyperlink to the trust FGM clinical guideline and the Local Safeguarding Children Board FGM guideline. Child sexual exploitation (CSE) was also included in the 2016 Safeguarding Children Policy and Procedures and included a hyperlink to the Local Safeguarding Children Board policy and supporting procedures. The mandatory reporting duty, which requires health professionals to report known cases of FGM in under 18 year olds to the police, was detailed in the trust's 2016 Safeguarding Children Policy and Procedures which instructed

staff to notify the safeguarding children team of any identified or suspected cases of FGM. The Named Nurse for Safeguarding Children coordinated the mandatory external reporting of cases of FGM and the number of cases reported was included in the safeguarding children and adults annual report.

- The trust had a safeguarding adult's policy in place. The safeguarding adults policy, dated September 2016, was linked to the North Yorkshire and West Yorkshire multiagency procedures and the trust's serious incident policy. Following two serious incidents in 2016 relating to safeguarding, we had concerns about the trust internal processes for recognising and raising a safeguarding concern. We reviewed the investigation reports, which made a number of recommendations. We found that the safeguarding policies had not been consistently followed, for example, incident forms had not been completed at the time of the incident.
- The named nurse for safeguarding children was in the process of establishing a new safeguarding supervision model, to ensure staff shared best practice and lessons learnt from serious incidents and serious case reviews involving children and young people.
- During our inspection, we found staff we spoke with were clear about their role in reporting and escalating a safeguarding concern. We found there were effective processes in place to protect children and vulnerable adults from abuse including positive examples within the emergency department.
- Training data showed the trust had achieved its 80% target for Level 1 safeguarding children and adult training and for Level 2 safeguarding children training with compliance rates of 94%, 90% and 92% respectively. The trust reported that 89% of required staff had completed Level 3 children's safeguarding training and 100% of required staff had completed safeguarding children Level 4 training.
- Annually the trust completed a safeguarding self-assessment framework to provide assurance and demonstrate compliance to the clinical commissioning group (CCG). An update in December 2016 showed work was on-going to ensure that a clinical supervision policy was in place and that safeguarding practice was included as a standard item.
- The trust had implemented an action plan in place in response to the Savile Inquiry.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on

how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The trust reported one never event from February 2016 to January 2017.

- Serious incidents were reported through the Strategic Executive Information System (STEIS). In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents, which met the reporting criteria set by NHS England from January 2016 and January 2017.
- There were 5,829 incidents reported to the National Reporting and Learning System (NRLS) from January 2016 to January 2017. Of these incidents, 4,202 (72%) resulted in no harm, 1,527 resulted in low harm (26%), 82 resulted in moderate harm, (1.4%), eight resulted in severe harm (0.1 %) and eight deaths were reported by the trust during this period (0.1%).
- The hospital had a serious incident policy which set out the process for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospitals electronic reporting system.
- There appeared to be an excessive number of incident reporting categories used to capture data and monitor themes and trends. The trust classified incidents in over 150 sub-categories.
- Staff were able to articulate how they would report an incident and understood their responsibilities to report safety incidents including near misses.
- We reviewed nine serious incident investigation reports and found these had been appropriately investigated in a timely manner and lessons learned.
- The trust held a quarterly assurance panel to seek assurance that action plans were completed and had been implemented following serious incident investigations and those requiring a root cause analysis. The panel was chaired by the Assistant Director of Healthcare Governance.
- A weekly quality review group had recently been established. This group reviewed incidents and complaints to ensure the senior team were aware of the incidents and the action taken.
- In the 2016 staff survey, 27% of staff reported witnessing potentially harmful errors, near misses or incidents in last month. This was better than the National average of 31%. The percentage of staff reporting errors, near misses or incidents witnessed in the last month was in line with the national average.

Summary of findings

- The trust had a Quality and Safety Matters newsletter that was sent to all staff. We saw the newsletter shared in January 2017 and saw this included shared learning from incidents.

Staffing

- Following the inspection in March 2016, we said the trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- Since the last inspection, in 2016, a nursing staffing review had been undertaken in accordance with the National Quality Board staffing guidance 'how to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability'. The trust used the safer nurse care tool and Royal College of Nurse staffing guidelines to assess nurse staffing levels. The trust reviewed nurse staffing levels every six months.
- The review had taken into account safety and patient experience performance, role requirements and developments and a discussion had taken place with each ward to incorporate professional judgement. A £1.2million investment in nurse staffing levels had been agreed.
- The trust had also commissioned an internal audit of nursing, midwifery and care staff following the last inspection in March 2016. The outcome of the audit identified limited assurance regarding the application of the methodology used to produce monthly staffing level reports. An action plan had been implemented as a result of the audit to improve the process and data validation and to define roles and responsibilities.
- The trust was actively recruiting and had taken some action to try and address the recruitment challenge. For example, the trust had 26 registered nurses working as band 3 healthcare assistants whilst they awaited their Nursing and Midwifery Council personal identification number to enable them to practice as registered nurses. Most of these nurses were international recruits who were going through the process of gaining the international English language test requirements. The trust had also recruited apprentice healthcare support workers, introduced discharge coordinators, provided additional administration support and had recruited to band 4, nurse associate roles.
- Nursing staffing levels had improved since the last inspection. However, there were still a number of nurse staffing vacancies. In February 2017, the trust's vacancy rate was 3% in comparison with November 2015 when the vacancy rate was 5%.

Summary of findings

- We found nursing staffing levels displayed within wards and departments. On some wards, the actual number of staff on duty were lower than the planned numbers especially in surgery and medicine.
- In medicine, we reviewed nurse staffing fill rates and nurse staffing ward rotas (covering December 2016 to March 2017). Between December 2016 and March 2017, all wards had registered nurse (RN) shifts unfilled each week. Where RN shifts were unfilled by existing staff, bank or agency, the service tried to backfill with additional HCA numbers. We found the numbers of shifts where the RN complement was less than planned figures ranged between one and nine shifts per week. This meant there was a shortfall in RN staffing against establishment figures on up to 43% of shifts.
- In surgery, we reviewed daily staffing reports for registered nurses and healthcare assistants and found there were a number of occasions where actual staffing levels did not meet planned. For example, from the 30 January 2017 to the 5 February 2017, across surgical services, out of 105 shifts, 34 shifts had below the planned registered nurse staffing levels. We reviewed data from the 11 March 2017 to the 17 March 2017 and found that out of 105 shifts, 45 shifts had below the planned nurse staffing levels.
- Children's services took into account guidance from the Royal College of Nursing (RCN) in relation to paediatric nurse staffing levels. The ward used an approved tool and template to calculate and record appropriate ratios. We reviewed staffing rotas on the children's ward in October, November, and December 2016 and found the service had met the appropriate RCN guidance
- The neonatal unit took into account guidance from the British Association of Perinatal Medicine (BAPM) in relation to neonatal nurse staffing levels. We reviewed staff rotas in March 2017 and noted there was appropriate cover for all shifts.
- At our previous inspection in 2016, we had significant concerns about staffing levels within critical care. We found out of sixteen shifts, only one shift, had the sufficient number of staff in line with national guidance (GPICS). During this inspection, we found nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patient's ratio for level two patients. The staffing ratio for coronary care patients who were level zero or one was one nurse to four patients ratio.
- Within ED, from December 2016 to March 2017, staffing data showed the department had sufficient qualified staff on duty to

meet the needs of patients. However, staff said that nurses were often asked to cover staff shortages on other wards. We saw that staff had reported staff shortages and skill mix as incidents on 33 occasions between January and December 2016.

- There was a shortage of specially trained children's nurses within ED. There were only two qualified children's nurses employed by the department. This was not in line with guidance form the Royal College of Nursing which states that there should be 24 hour children's nurse presence in the department. Additionally, there were no advanced paediatric life support (APLS) qualified nurses in the department as required by the 2012 intercollegiate standards.
- Within maternity the service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with an average ratio of 1:26 between April 2016 and February 2017, this was better that the recommended 1:28.
- Within ED the department there was funding for ten whole time equivalent (WTE) consultants. At the time of inspection there were seven WTE consultants employed in the department, resulting in a vacancy rate of 33%. Staff said shifts were covered by existing staff or locum consultants.
- Children's services had a full complement of 10 whole time equivalent (WTE) consultants in post and six junior doctors. This demonstrated an improvement since the previous CQC inspection and the consultant rota was compliant with the Royal College of Paediatrics and Child Health - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).
- In 2016, we said the trust must ensure that a multi-disciplinary clinical ward round within intensive care must take place in accordance with national standards (GPICS). On the critical care unit we saw evidence in patients records that twice daily consultant led ward rounds were completed Monday to Friday which was in line with GPICS standards. The consultants had recently changed their work pattern to deliver continuity of care which was in line with GPICS standards.
- The delivery suite had consultant cover 40 hours per week; there was also consultant cover available out of hours. This is in line with the Royal College of Obstetrics and Gynaecology (RCOG) recommendations for the number of births.

Medicines

Summary of findings

- In 2016, we said the trust must ensure the safe storage and administrations of medicines. During the inspection we found medicines were stored securely in all areas we visited with the exception of maternity, where medicines were stored in an unlocked clean utility and on trolleys in the corridor.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- Controlled drugs were stored securely throughout the trust with access restricted to authorised staff and balance checks were performed in line with the trust's policy.
- We checked medicines and equipment for emergency use and found they were readily available and checked regularly in accordance with the trust policy.
- Trust policies were regularly reviewed and covered all aspects of medicines management. These were accessible via the hospital intranet to all staff.
- The ward-based clinical pharmacy service was available between the hours of 9am to 5.30pm Monday to Friday and a limited service between the hours of 9am to 4pm on a Saturday and 10am to 12.30pm on a Sunday. Outside of these hours, an on call service was provided.
- Medicines records were completed using an Electronic Prescribing and Medicines Administration (EPMA) system. This system was effectively used by nursing staff to administer and record medicines
- Pharmacy staff checked (reconciled) patients' medicines on admission to medical and surgical wards and the trust audited medicines reconciliation rates each month. The latest figures for January 2017 showed that an average of 82% of adults admitted to acute medicine unit had their medicines reconciled within 24 hours of admission. The trust did not routinely complete medicines reconciliation on Maternity or Children's wards. For the medicines charts we reviewed, we found that nine out of 19 had medicines reconciliation ticked as completed. However, outstanding actions had not been completed or interventions had not been followed up. Patient's notes did not have entries to explain why medicines were not prescribed and changes made were not communicated. We saw one patient had been prescribed two inhalers from a

similar class, which are contraindicated when taken together. This had been noted by the pharmacist, however no further action had been taken or recorded and nine days later we saw the patient was still taking both medicines.

- Medicines management was audited routinely across the trust and included medicines reconciliation, safe and secure storage of medicines, controlled drugs and antimicrobial audits. Audit results were disseminated through appropriate groups and action plans were prepared and acted upon. The trust audited the time taken to dispense non-complex and complex discharge prescriptions, which had a key performance indicator of 80% within one hour and two hours, respectively. A recent audit showed that the trust had not achieved its indicator for non-complex discharges during December 2016 (69%) or January 2017 (74%).
- Arrangements were in place to ensure medicines incidents were reported, recorded and investigated through the trust governance arrangements. The Medicines Safety Officer described how incidents were analysed and learning disseminated across the trust. This process could also be seen in the minutes of the Medicines Safety Group and the Quality and Safety group

Assessing and responding to risk

- At the inspection in March 2016, we had concerns about the escalation process of deteriorating patients particularly with medical care and surgery. When we inspected in September 2016, we found clinical observations, recording of NEWS scores and adherence to NEWs triggers had improved.
- At this inspection, we found the improvement had been sustained. Staff used NEWS (National Early Warning Score) or PAWS (Paediatric Advance Warning Score) to monitor patients. Patient's observations were correctly recorded and patients who were at risk of deteriorating were escalated in a timely manner.
- Senior nurses audited key performance indicators relevant to patient risk. For example, within medicine, auditors found NEWS compliance (the recording of clinical observations and responses to escalation triggers) on wards against the nine criteria was good. All wards audited reported averaged compliance in excess of 95%.
- At the inspection in March 2016, we found 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. At this

inspection, although the service audited the completion of the WHO checklist monthly as part of theatre's key performance indicators and found good levels of compliance, we observed that inconsistencies were still evident.

- In the cardiac catheter lab, patients waited in the adjacent corridor to be received by the catheter lab staff. There was no facility for patients waiting to contact staff in the event of a care need or emergency.
- On wards where patients were being monitored by telemetry (remote cardiac monitoring), staff held a bleep for direct contact from CCU in the event of a change in a patient's cardiac rhythm. Wards also had a 'hot-phone' solely for contact to/from CCU. This had improved safety and communications identified during our previous inspection.
- There was a Frailty Elderly Pathway Team who demonstrated a proactive approach to deal with vulnerable patients to ensure they got the right care as early as possible following hospital arrival. The team had built relationships across the internal multidisciplinary team, with social care colleagues and external care providers. The team have audited their performance and reported successes in admission avoidance, reduced length of stay, less intra-hospital moves, reduction in readmission rates, cost savings and improved patient experience.

Are services at this trust effective?

At the previous inspection in March 2016, we rated the trust as good for effective.

At this inspection, we inspected effective in critical care only. We rated this as good at this inspection. Please see the report for critical care for detailed findings.

Are services at this trust caring?

At the previous inspection in March 2016, we rated the trust as good for caring.

At this inspection, we inspected caring in critical care only. We rated this as good at this inspection. Please see the report for critical care for detailed findings.

Are services at this trust responsive?

At the previous inspection in March 2016, we rated the trust as good for responsive.

At this inspection, we inspected responsive in critical care only. We rated this as requires improvement at this inspection. Please see the report for critical care for detailed findings.

Summary of findings

Are services at this trust well-led?

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

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

- Although there had been changes made to the governance structure since our last inspection, the reporting structure appeared complex and we found this was not clearly understood within the organisation.
- We were not assured from some of the recently reported incidents that the systems and processes were fully effective to ensure comprehensive learning.
- The trust was often reactive, rather than proactive in identifying areas for development and the pace of change could be improved.
- The trust was to review the WRES work plan in line with the published 2017 guidance to ensure actions addressed the issues identified in the 2016 NHS staff survey and the 2017 Workforce Race Equality Standard (WRES) data analysis.

However:

- Staff reported an improvement in the culture since our previous inspection.
- There continued to be a strong commitment to public engagement and we found creative initiatives to develop this further.

Leadership of the trust

- The membership of the unitary trust board was relatively stable, although there had been some changes since the last inspection in March 2016. An interim director of nursing had been in post since October 2016. There had also been changes in the non-executive directors with three new appointments. The chair had been in post for almost three years and at the time of inspection had been asked if he was willing to serve a second three year term; the decision to approve his re-appointment was to be considered by the Council of Governors.
- Staff were positive about the board level changes, in particular about the impact of the interim director of nursing.
- We found that the leadership team had led a number of improvements to services since the inspection in March 2016. However, there were still some areas that required further improvement.

Summary of findings

- The trust had three clinical groups (integrated care, surgery and women's and children's) plus a further two which were estates and facilities and a corporate group.
- Each clinical care group was led by a head of nursing, general manager and service specific clinical directors. The trust had made changes since the previous inspection to strengthen the leadership at this level in the organisation. Within critical care, there had been a significant change to the leadership team since our 2016 inspections. All staff were positive about the team.
- The trust were looking to develop Associate Medical Director roles with the aim of the post holders holding corporate portfolios.
- The trust had processes in place for the leadership team to network with other senior leaders within the health economy and with the Council of Governors. We were told that the relationship with the Governors was mixed, however the importance of this group was acknowledged as they were seen as key link to the community.
- We were told that there were opportunities for leadership development across the trust including 'Rising Stars', 'Right Care New Leaders' for new clinical leaders, the new 'Right Care' Senior Leaders Programme for service group leadership teams, executive coaching and support for external development.
- Senior leaders could access executive coaching to support them in developing leadership roles. At December 2016, 90.6% of staff had received an appraisal.

Vision and strategy

- The trust had a well-established 'right care' strategy. The implementation of the strategy was underpinned by programme boards. Implementation was reported as slower than anticipated due to financial and activity pressures.
- Staff across the trust were familiar with the 'right care' strategy.
- There were some inconsistencies in how the trust strategy linked to individual service strategies. For example, in medicine, the group vision aligned to the overreaching trust vision with a strategy which identified priorities for the group in the coming financial year and within surgical services a two year annual plan for 2017/2019 had been developed that had been reviewed and signed off by the trust board. However, there was no specific strategy for maternity and gynaecology and within critical care; there was an operational review rather than a clear strategy. This was consistent with the findings at our previous inspection in March 2016.

Summary of findings

- A nursing and midwifery strategy for 2017 to 2020 was in the process of being developed, however we saw that ward development plans were in place and it was anticipated that these plans would support the operationalisation of the nursing strategy.
- The trust had a people plan in place which covered a two year period and was linked to the vision and strategy.

Governance, risk management and quality measurement

- There had been some changes to the governance structure since the previous inspection to ensure more robust arrangements, including standardised agendas and reporting. However, the reporting structure appeared complex and we found this was not clearly understood within the organisation.
- We were not assured from some of the recently reported incidents that the systems and processes were fully effective. A quality review group that met weekly to review incidents and safety issues had recently been established and it was too early to determine the impact of this.
- Performance and safety information was reviewed at the executive assurance group (EAG) meeting prior to being viewed by the board. No non-executive directors attended the EAG, therefore the first time they reviewed this information was at the board meetings. However, we were informed that the board was seen as the key quality committee at the trust and the non-executive directors had requested to have access to detailed information. It was noted at the board meetings, there was a lot of data presented, but limited triangulation.
- Following the previous inspection in March 2016, a CQC board assurance sub-committee was established. This was an additional committee and the board were of the opinion that this was needed to ensure that the response to the 2016 CQC inspection was delivered at pace and was embedded.
- During the inspection, we attended a meeting of the board of directors. We saw this was well attended and there was appropriate discussion and challenge from board members, including the non-executive directors.
- There was a quality assurance and improvement committee which reported to the board. This committee targeted specific areas within the clinical care groups. The clinical care groups presented to the committee on an annual basis. The quality assurance and improvement committee did not review overall incidents or complaints data. It was unclear how the committee provided wider assurance to the board regarding quality.

Summary of findings

- There was a board assurance framework in place that was reviewed quarterly by the executive directors. The senior team were able to articulate the key risks for the trust that included staffing and patient flow through the organisation.
- The trust's corporate risk register identified a lead executive and had review dates for each risk. Included on the corporate risk register were risks that scored twelve and above; risks scored at nine and above were reviewed by EAG. The risk register was reviewed monthly at the executive assurance group.
- The trust had a patient safety scorecard which identified key targets and trends for safety issues such as falls, pressure ulcers and medication administration errors. This was reviewed at board meetings. This contained detailed data and was supported by reports included at each board meeting, with the inclusion where applicable, of regional and national benchmarking to allow meaningful comparison alongside the local average, for example with regard to C-sections. The trust had an internal audit plan set and reviewed by the Audit Committee, the annual audit plan used information from the BAF and corporate risk register plus a range of other sources for example the CQC report.
- The trust had a cost improvement programme (CIP). Each programme was discussed, developed and agreed with the relevant management leads within the groups. The executive lead was the Director of Finance. Each cost improvement plan was quality impact assessed to reflect any potential risks to quality improvement.
- There was a performance framework in place which was led by the Director of Finance, reporting was through the Delivery Assurance Groups (DAG) which then fed into the EAG. Integrated Performance Assurance reports provided assurance to the EAG.
- The trust had taken actions and developed a task and finish group to support implementation of the recommendations made in the 'learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England' which was published in December 2016.

Culture within the trust

- The leadership team had worked hard to improve the culture. Staff described an improvement in the culture since our previous inspection. Staff spoke positively about the support from the matrons and the senior leadership team and said they were more visible in clinical areas. Staff on the critical care unit told us it felt like a different place to the one they worked on during our 2016 inspection.

- However, staff morale remained variable and staffing moves was having a negative impact.
- In the NHS staff survey 2016, the trust performed better than other trusts in eleven questions, about the same as other trusts in 10 questions and worse than other trusts in 11 questions.
- A key finding for the percentage of staff or colleagues reporting most recent experience of harassment, bullying or abuse showed the largest change from the 2015 staff survey. However, although improved, it remained worse when compared with other acute trusts in England.
- NHS staff survey (2016) performance on other questions relating to bullying, harassment and equal opportunities showed the same or better results when compared to other acute trusts in England.
- The trust's sickness levels between October 2015 and August 2016 were similar to the England average.
- The trust had a 'freedom to speak up and whistleblowing policy' in place. They had appointed a freedom to speak up guardian at the trust in January 2017.
- The trust had incorporated the duty of candour requirements into the serious incident and being open policy. The trust's incident reporting system provided an audit trail on compliance with this requirement.
- The interim director of nursing had developed a health care assistant support group and a student forum.

Equalities and Diversity – including Workforce Race Equality Standard

- As part of this inspection, we reviewed the trust's implementation of the Workforce Race Equality Standard (WRES) and it's approach to equality and diversity. The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation.
- The trust had an inclusion strategy for 2016 to 2020, which was published on the trust's website and had been presented to the trust board in January 2016. The strategy referred to the Equality Delivery System outcomes and the Workforce Race Equality Standard (WRES). Prior to the CQC inspection, the trust had decided to fundamentally restructure and reconfigure its approach to equality and diversity in order to deliver on the

trust's inclusion strategy and board commitments. At the time of inspection, the trust was changing it's approach to work on equality and diversity. This aimed to make it more embedded and more directly led at director level.

- The trust had published information on the WRES indicators, with associated actions, on the trust website. The trust had also published information relating to health inequalities and protected characteristics across the four Bradford and district health care providers and in relation to Equality Delivery System objectives. Following the inspection, the trust had also published workforce profile data relating to protected characteristics, from April 2017.
- Data from the 2016 NHS Staff Survey showed a positive picture with regards to race equality. BME staff reported a more favourable employee experience compared to white staff, with overall engagement at 4 compared to 3.8 for white staff. BME staff reported more positive results compared to white colleagues in relation to quality of appraisals, recommending the organisation as a place to work or receive treatment and support from managers. Areas where BME staff reported a less favourable experience included experiencing harassment, bullying and abuse from staff in the last 12 months (27% compared to 24%), and experiencing discrimination at work. The trust told us these areas will form the basis of a refreshed WRES action plan.
- The trust had taken a number of positive measures to improve overall employee experience and promote inclusion, for example recruiting apprentices and embedding its 'Right Care' behaviours into the trust people plan and into new leadership development programmes. Some parts of the WRES action plan could be further strengthened to ensure they specifically address the inequalities identified.
- The trust had previously established a disability focus group in 2015 and were developing support groups for people with other protected characteristics at the time of inspection. The new BME staff focus group had therefore not yet had the opportunity to be involved in the development of the WRES work. However, BME staff told us they had felt reassured by messages from the Chief Executive about valuing diverse staff groups around the time of the EU referendum. The board had also invited two overseas nurses working at the trust to share their experiences at a Board meeting (July 2016).

Fit and Proper Persons

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had an updated standard operating procedure for the fit and proper person test for the Board of Directors. This had been approved in January 2017. This detailed the requirements in accordance with the regulation.
- There was an annual declaration of on-going compliance and clear procedures and checks for new applicants.
- We reviewed six personnel files for executive and non-executive directors and found these to be compliant with the regulation.

Public engagement

- The interim Director of Nursing was the executive lead for patient experience and engagement.
- A Patient & Public Experience & Engagement Strategy for 2016-2020 was in place.
- A patient experience group met monthly and reported to the executive assurance group, a sub-group of the board.
- The trust undertook a real time inpatient survey to gather regular feedback from patients and to support quality improvement. The survey was carried out by a team of volunteers who interviewed patients on each ward on a weekly basis. We saw the results for the period October to December 2016. A total of 310 patients had been completed the survey. The data was reported and discussed at local and trust-wide meetings and included in the quarterly quality and safety reports and the annual Quality Account.
- There was a patient and carer panel, which championed the experience of patients, carers and visitors. The panel produced an annual report and reported directly into the trust's patient and public engagement and experience steering group.
- Staff proactively engaged with young people through the Airedale Hospital Youth Forum. Young people, with support from healthcare staff, primarily led the forum and their aim was to be the voice for children and young people attending the hospital.
- The trust's Council of Governors has 31 members, including 19 public governors. The Council of Governors engaged with the public and patients to ask their views and then fed back to the board. We saw that feedback had been given to the Council of actions taken in response to this feedback.

- Patients and readers' panel members had been involved in a project to improve patient information and an engagement event had been held in October 2016.
- We saw the trust actively engaged with the local Healthwatch organisations.
- A patient story was shared at each board meeting. Although there was a mix of positive and negative stories, there was no structured plan to ensure the weighting of patient stories to complaints categories, to ensure focus on quality improvement.
- Patient stories were recorded and accessible for clinical teams on electronic tablets to share learning.

Staff engagement

- In the staff survey results 2016, published 7 March 2017, the overall indicator of staff engagement for Airedale NHS Foundation Trust was average when compared with trusts of a similar type. This had remained consistent from the 2015 survey results.
- The trust undertook a quarterly 'pulse check' with staff. Results from November 2016 showed 77% of staff would recommend the trust as a place to work, compared with 9% who would not.
- The trust held a staff recognition scheme and gave 'Pride of Airedale' awards.
- There had been a recent administration and clerical review across the trust. This had resulted in a number of staff changes. Staff were mostly understanding of the need for change; however some staff reported a lack of engagement with this and other organisational changes.

Innovation, improvement and sustainability

- The trust were working with other providers to develop more sustainable services for the local population.
- The trust was a pilot site for training nurse associates. The trust was supporting these staff to undertake a foundation degree programme.
- The trust had an established telemedicine hub that provided services to nursing and residential care homes, prisons and patients at the end of life.
- The trust was a vanguard site for 'The Serious Illness Care Program' and were also part of the Airedale Partner's Enhanced Health in Care Homes vanguard.
- The Child Development Centre had recently won an award for helping children who had trouble in communicating with others. The unit had achieved 'Makaton-friendly' status, recognised and endorsed by the Makaton charity itself.

Summary of findings

Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

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

Overview of ratings

Our ratings for Airedale General Hospital

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

Our ratings for Airedale NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- The Frailty Elderly Pathway Team demonstrated a proactive approach to deal with vulnerable patients to ensure they got the right care as early as possible following hospital arrival. The team had built relationships across the internal multidisciplinary team, with social care colleagues and external care providers. The team have audited their performance and reported successes in admission avoidance, reduced length of stay, less intra-hospital moves, reduction in readmission rates, cost savings and improved patient experience. The team had been nominated for a national award.
- Through the effective use of an electronic record and an integration system, a shared record could be accessed securely by partners across care settings, including GPs, to obtain a tailored view of an individual's information.

Areas for improvement

Action the trust MUST take to improve

Trust-wide

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

Urgent and emergency care services

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

Medical care services

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

Surgery services

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

Critical care

- The trust must continue to implement the follow up clinic and rehabilitation after critical illness in line with Guidelines for the Provision of Intensive Care Services 2015 and NICE CG83 Rehabilitation after critical illness.

Outstanding practice and areas for improvement

- The trust must review the process of identifying, recording and reporting mixed sex accommodation occurrences and breaches on ward 16.
- The trust must introduce a robust, proactive approach to risk assessment and risk management which includes regular review.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

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