Bedfordshire Hospitals NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Bedfordshire Hospitals NHS Foundation Trust (BHFT) formed as a new entity in April 2020 as a result of a merger and acquisition arrangement of Luton and Dunstable Hospital NHS Foundation Trust and Bedford Hospitals NHS Trust. BHFT provides a comprehensive range of acute and specialist service from the two acute locations. The trust also manages some activity at its five other satellite sites:

Luton and Dunstable University Hospital Orthopaedic Centre, Arndale House, Archer Unit, Chaul End Community Centre Health Suite, Kingsway medical centre.

The trust has 1,024 acute inpatient beds, 36 critical care beds and 106 maternity beds and employs around 8,022 full time equivalent staff across the sites. Of these staff, 2,058 are nursing and midwifery staff, 1,082 are medical staff and 4,007 are classified as other staff (Data taken from Insight 22 June 2022).

The main hospitals are located in Bedford and Luton and serve a population of around 700,000 people within the local catchment areas covering South Bedfordshire, Luton and parts of Hertfordshire and Buckinghamshire. Services are mainly commissioned by NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board.

At the time of our inspection, the new entity of BHFT had not yet been fully inspected. This means that some core services at Bedford Hospital location do not yet have ratings. All core services at Luton Hospital location retain their previous ratings.

We carried out unannounced focused and comprehensive inspections of 6 of the acute services provided by this trust:

- Urgent and emergency care at both acute sites because we had concerns about the quality of services.
- Medical Care (including older people's care) at both acute sites because we had concerns about the quality of services
- Maternity at both acute sites to look at those parts of the service that did not meet legal requirements and because we had concerns about the quality of services.

Our findings

- We also inspected the well-led key question for the trust overall.

When a trust acquires another trust in order to improve the quality and safety of care, we do not aggregate ratings from the previously separate trust at trust level for up to two years. Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed since the COVID-19 pandemic.

The ratings for the trust in this report are therefore based only on the ratings for Luton and Dunstable Hospital and our rating of leadership at the trust level.

At Bedford Hospital we inspected only those services where we were aware of current risks. We did not rate the hospital overall.

This is the first time we are rating this trust. We rated them as good because:

- We rated safe as requires improvement and effective, caring, responsive and well-led as good.
- We rated 3 of the trust's 16 services we inspected as good and 3 as requires improvement. **In rating the trust, we took into account the current ratings of the 10 services not inspected this time**. As some of the inspections we undertook were focused and we have not undertaken an inspection of all core services that have not been previously rated post-merger, not all ratings have been aggregated to trust level.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and provided emotional support to patients, families and carers.
- Leaders were visible and approachable and provided staff with development opportunities.
- Leaders planned services to meet the needs of the community.
- Staff understood the service's values and were generally focused on the needs of patients receiving care.
- Staff were clear about their roles and accountabilities.

However:

- Staff did not always complete mandatory training and there were not always enough staff to meet the needs of patients.
- People could not always access the care and treatment they needed in a timely manner. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

How we carried out the inspection

We carried out the core service inspections from 2 to 3 August 2022 and the well-led inspection on 20 and 21 September. We visited areas relevant to each of the core services inspected and spoke with a number of patients, staff and patient representatives.

We spoke with 144 members of staff at all levels of the organisation across various specialities and including healthcare assistants, nurses, midwives, junior doctors, pharmacy staff, consultants and administrative staff.

Our findings

We also spoke with 27 patients and 5 relatives. We observed care and reviewed 91 sets of care records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments, training records and audit results.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Luton and Dunstable Hospital – Urgent & Emergency Care

- The medical staff rotas were organised on a three-shift structure with consistent skill mix that allowed consultant led handovers to take place 3 times a day. This promoted quality and safety of clinical care.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 15 legal requirements. This action related to 6 services.

Bedford Hospital – Urgent & Emergency Care

- The trust must ensure all medical staff mandatory training is completed in line with trust targets. (Regulation 12(2)(c))
- The trust must ensure people can access the service when they need it, and that waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line with national standards. (Regulation 17(1)(2)(a))

Bedford Hospital – Medicine (including older people's medicine)

- The trust must ensure that all ward areas and equipment are clean and well-maintained. (Regulation 12 (2) (d)(h))
- The trust must ensure medical gas cylinders are kept in a secure purpose-built cylinder store that should allow the cylinders to be kept dry and in a clean condition in accordance with HTM-02 guidance. (Regulation 12 (2) (e)(g))
- The trust must ensure fire doors/exits are kept shut in accordance with HTM 05-03 to avoid compromising fire safety. (Regulation 12 (2)(d))
- The trust must ensure it carries out audits to monitor performance and identify areas where improvements are required, and ensure actions arising from audits are implemented. (Regulation 17 (2) (a))

Our findings

Bedford Hospital – Maternity

- The trust must ensure all staff complete safeguarding training for adults and children to the level required by their role. (Regulation 12 (1) (2)(c))
- The trust must ensure that staff completion of mandatory training is in line with the trust target. (Regulation 18 (2)(a))
- The trust must ensure that all areas used by patients have effective infection control and prevention guidance and these are followed. (Regulation 12 (2)(h))

Luton and Dunstable Hospital – Urgent & Emergency Care

- The trust must ensure all mandatory training is completed in line with trust targets. (Regulation 18 (2)(a))
- The trust must ensure all equipment checks are completed in accordance with the trust policy. (Regulation 12 (2) (d) (h))
- The trust must ensure people can access the service when they need it and improve waiting times for patients. (Regulation 12(2)(a))

Luton and Dunstable Hospital – Medicine (including older people's medicine)

- The trust must ensure that staff implement infection prevention control measures effectively (Regulation 12(2)(h))

Luton and Dunstable Hospital – Maternity

- The trust must ensure that all staff have completed safeguarding training for adults and children to the level required by their role. (Regulation 12 (1) (2)(c))
- The trust must ensure all fire doors are closed. (Regulation 12(2)(d))

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that all staff complete statutory and mandatory training. (Regulation 12)
- The trust should ensure that there are enough staff with the right skills and qualifications to meet the needs of patients. (Regulation 18)
- The trust should ensure that there is capacity within the pharmacy service to carry out effective governance. (Regulation 17)
- The trust should ensure that Equality Impact Assessments are consistently undertaken and they continue to drive the Equality Diversity and Human Rights strategy. (Regulation 17)

Bedford Hospital – Urgent & Emergency Care

- The service should ensure it provides mandatory training in key skills to all appropriate staff. (Regulation 17)

Bedford Hospital – Medicine (including older people's medicine)

- The service should ensure all nursing and medical staff receive and keep up to date with mandatory training. (Regulation 18)

Our findings

- The service should ensure that all call bells are within the reach of patients at all times. (Regulation 12)
- The service should ensure staff carry out daily safety checks of specialist equipment such as suction and defibrillators and ensure that all electrical equipment has up to date PAT testing. (Regulation 12)
- The service should ensure that patient allergies are recorded on medicines prescription records. (Regulation 12)
- The service should ensure that patient records are stored securely at all times. (Regulation 17)
- The service should ensure fridge temperatures where medicines are stored are consistently recorded to ensure that medicines are always safe and effective to use. (Regulation 12)
- The service should ensure that endoscopy patients are recovered in an area with patient toilet facilities available including when escalation protocols are in place. (Regulation 12)
- The trust should ensure it has enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. (Regulation 18)

Bedford Hospital – Maternity

- The trust should ensure there are adequate numbers of staff to meet the demands of the service. (Regulation 18)
- The trust should ensure the maternity triage area is suitable to meet the service's needs. (Regulation 15)
- The trust should ensure all medicines are given as prescribed or the prescription stopped in line with guidelines. (Regulation 12)

Luton and Dunstable Hospital – Urgent & Emergency Care

- The service should ensure equipment is regularly reviewed and tested. (Regulation 12)
- The service should ensure sepsis screening is always indicated in patient records. (Regulation 12)
- The service should ensure staff appraisal rates are in line with trust targets. (Regulation 17)

Luton and Dunstable Hospital – Medicine (including older people's medicine)

- The provider should ensure that all staff keep up to date with statutory and mandatory training. (Regulation 12)
- The provider should ensure temperature monitoring and control of all areas where medicines are stored, in line with national guidance. (Regulation 12)
- The provider should ensure there are enough nursing and support staff with the right qualifications, skills, training and experience. (Regulation 18)
- The provider should ensure that there is a process to demonstrate when equipment has been cleaned and ready for use. (Regulation 12)
- The provider should ensure that emergency call bells are accessible in-patient bathrooms. (Regulation 12)
- The provider should ensure referral to treatment waiting times are met. (Regulation 17)
- The provider should ensure that equipment is stored safely. (Regulation 15)
- The provider should ensure adequate space is provided for patient waiting areas. (Regulation 15)
- The provider should ensure patients are appropriately pre-assessed before endoscopy procedures. (Regulation 12)

Our findings

- The provider should consider how to ensure that clinical hand wash sinks allow non-touch handwashing techniques.

Luton and Dunstable Hospital – Maternity

- The trust should ensure there are adequate numbers of staff to meet the demands of the service. (Regulation 18)
- The trust should ensure it appraises all staff's work performance regularly to provide support and development. (Regulation 18)
- The trust should ensure that staff access the most recent policy guidance. (Regulation 17)
- The trust should ensure medicines are stored correctly. (Regulation 12)
- The trust should ensure all records are stored securely. (Regulation 17)
- The trust should ensure all women's risk assessments are completed and recorded. (Regulation 12)
- The trust should ensure the information technology system is fit for purpose and can maintain the accuracy of data. (Regulation 17)

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services; in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This is the first time we have rated well-led at the trust. We rated it as good.

Leadership

Leaders had the skills and abilities to run the services provided by the trust. They understood and managed the priorities and issues the trust faced. They were visible and approachable in the organisation for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience they needed to deliver quality sustainable care. This was confirmed through our interviews with senior leaders and review of documents and personnel files. The trust had a process in place to ensure that senior leaders were appointed in line with Regulation 5 of the Health and Social Care Act 2014 (Fit and Proper Persons required) and there was on-going review. Leaders understood the unique qualities and needs of their team. Most of the executive leadership team had worked in the predecessor organisations, with the majority having been at the Luton and Dunstable Hospital NHS Foundation Trust. This meant the team had had the opportunity to form a collective leadership team before the merger. However, members of staff at various levels told us that this had contributed to an initial feeling from staff at Bedford Hospital that the merger was a 'takeover'. Senior leaders were aware of this and had focused on supporting the clinical service lines to help develop a single trust culture.

Leaders understood the challenges to quality and sustainability and identified the actions needed to address them. Leaders worked collectively to understand challenges and identify actions. For example, senior leaders told us that the merger occurring at the height of the pandemic had meant that plans to develop a trust-wide strategy had been delayed

as the organisation was dealing with the demand and COVID-19. This had been discussed at board meetings and non-executive directors told us they had ensured that this had remained on the agenda. In December 2021, the trust commissioned an external review of the board to help them understand the challenges for the leadership team and developed an action plan based on the recommendations, some of the actions were already in progress.

The trust board included a group of experienced non-executive and executive directors. However, staff told us that the trust board lacked diversity and was not reflective of the community served or workforce. This was also evident from the trust's Workforce Race Equality Standards 2021/22 (see more in Culture section of the report). In our interviews with senior leaders they acknowledged that there was more to be done in this area to ensure inclusive leadership at all levels.

The Council of Governors was made up of members of the public and staff as part of the foundation trust membership. Governors met regularly and described a good working relationship with the leadership team.

There was a formalised leadership strategy in place which included talent management and succession planning. There were clear priorities for ensuring sustainable, compassionate and effective leadership. This was being achieved through the development of clinical service lines that had replaced the trust's traditional divisional leadership structure. The trust had 36 clinical service lines for each speciality that worked together across both sites. Each clinical service line had clinical, nursing and operational leadership and was supported directly by executives. Senior leaders told us this meant every service line from urology to limb fitting had direct access to executive leadership to discuss the specific needs of their service (frequency of access/review was dependent upon level of risk). Leaders said this model of leadership was developed to create more opportunities for leaders to grow and to ensure that services were being clinically led by those directly involved with that service's delivery.

Leaders were visible and approachable. Senior leaders told us they worked hard to be visible throughout the organisation. Leaders told us this had been more important since the challenges of the pandemic and consequent pressures on the healthcare system continued. Our findings from the core service inspections confirmed that leaders were visible and approachable. Non-executive directors had been less able to conduct ward walkarounds during the periods of restricted visiting; however, they had continued to visit areas and meet staff where appropriate and safe to do so.

Vision and Strategy

The trust had a vision for what it wanted to achieve. They were in the process of developing a strategy to turn it into action with all relevant stakeholders. The vision was focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. However, there was not an over-arching strategy for achieving the priorities, this was being developed at the time of our inspection. Senior leaders told us that the development of the formal strategy had been delayed due to the significant impact of COVID-19 and the need to prioritise service delivery and reconfigurations. The trust had continued to develop other key enabler strategies that would feed into an overarching strategy. This included the trust clinical, people and estates strategies. Most of the services we inspected had developed their own strategies which linked to the underpinning strategy and trust vison and values.

Our findings

Whilst there had been no formalised strategy in place since 2020 the trust has defined their strategic objectives annually. These have been based on their mission statement and aligned to local plans within the wider health and care economy. The CEO told us that a part of the strategy was reliant upon how the Integrated Care System (ICS) and Integrated Care Board (ICB) developed further and the way that the system worked together. Senior leaders within the trust were working as key players in the system partnership.

The trust values had been developed with staff in 2019/20 with the merger. All staff we spoke with during the core service inspections knew the trust values and vision. The trust leadership team had worked hard to embed the values in policies and practice. This included developing 'values-based' recruitment and appraisals processes.

Progress of delivery against the enabling strategies was monitored at various committees. The trust recognised that there would need to be some restructuring of committees to ensure oversight of the overarching strategy.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust worked to have an open culture where patients, their families and staff could raise concerns without fear, however, not all staff felt comfortable raising concerns. The trust had a plan to promote equality and diversity in daily work, and provided opportunities for career development.

Staff we spoke with told us they felt supported, respected and valued**.** Our interviews with staff at all levels demonstrated that the culture was mainly centred on the needs and experience of people who used the services. Staff told us they were proud to work for the organisation. However, the increased demand and pressures on services had impacted on staff well-being with some staff experiencing 'burnout'.

There was a strong emphasis on the safety and well-being of staff. The trust had introduced resources and developed a number of tools to support staff mental well-being. This included increased provision of counselling and psychology services and well-being hubs and events. Senior leaders recognised that the demand on services had a profound impact on staff's physical and mental well-being. Leaders we spoke with spoke passionately about the resilience of staff and were proud of their teams.

The NHS staff survey 2021 results were the first for the newly merged trust. The benchmark scores were generally average. The trust had a comprehensive programme of gathering feedback from staff utilising internal methods such as surveys and focus groups. Clinical service lines developed action plans based on the various sources of feedback.

The trust had a diverse workforce. As of July 2021, the trust reported that 43.3% of the workforce was from black and minority ethnic (BME) backgrounds and 53.2% were from white backgrounds, 2.3% of staff reported having a disability. The trust board and senior leadership team was not reflective of the workforce or community served.

The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reports for the trust demonstrated there was a lack of diversity in senior leadership posts and the experience for people from BME backgrounds was not the same as those from a white background. Of the executive board members at the trust, 0% were from BME background and 57% were female. Of the non-executive board members 12.5% were from BME background and 25% were female.

There was an equality, diversity and human rights (EDHR) strategy framework in place and an EDHR committee was established. Our review of evidence and interviews with leaders demonstrated the organisation was aware of the need

to be more inclusive and was exploring ways to ensure all staff had equal opportunities. This included developing inclusive leadership pathways and working with equality networks to understand the challenges. This work was in its early stages, staff we spoke with at all levels were keen for the organisation to take meaningful steps to drive the equality, diversity and inclusion agenda.

The trust did not routinely conduct equality impact assessments when new policies, systems or processes were introduced. Senior leaders acknowledged that this was an area for improvement and were committed to ensuring they took steps to address this gap.

Action was taken to address behaviour and performance that was not consistent with the vision and values regardless of seniority. The trust had a number of human resources (HR) and organisational development (OD) policies and tools to support staff with disciplinary, performance and employee relationship matters. This included supportive performance reviews and conflict resolution processes.

The trust worked hard to encourage openness and honesty at all levels within the organisation and for those who used services. However, CQC received 22 whistle-blowing enquiries from BHFT staff members from September 2021 to September 2022. The themes from the whistle-blowers were around staffing pressures, bullying and harassment and equality and diversity. This demonstrated that despite having various channels for staff to raise concerns, some people still felt that their voices were not being heard by senior leaders.

The trust had a policy about being open and transparent and there were Freedom To Speak Up (FTSU) guardians. Our interviews with the FTSU guardians demonstrated that the FTSU service was in line with national guidance. Guardians were at both Bedford and Luton sites and were visible and accessible for staff. There were also FTSU champions within the clinical service lines. FTSU guardians reported a good working relationship with the executive leadership team and the non-executive director sponsor.

People who received care at the trust and their relatives and carers could raise concerns and complaints to the trust. Our review of documentation and conversations with staff demonstrated the trust had a process to ensure staff carried out duty of candour when required to do so. Complaints were generally managed in line with trust policy and there was evidence of learning from complaints at trust level and at core service level.

Governance

Leaders generally operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were structures, processes and systems of accountability to support the delivery of the strategy and sustainable care. These had been recently reviewed to make improvements before our inspection and after the most recent external review.

The governance structure was divided into 2 areas – performance and assurance. There were an appropriate number of assurance committees including audit, finance, quality, sustainability and remuneration. There were several sub-committees for assurance including health and safety and equality and diversity.

Our findings

The board assurance framework (BAF) was focused on strategic risks in line with the trust's corporate objectives as outlined in the trust's annual report. There were links to the corporate risk register and risk owners provided updates on any mitigating actions and control measures through the relevant committee. The trust had an external auditor to provide them with assurances with regards to their risk and assurance processes.

All levels of governance and management generally functioned effectively and interacted with each other appropriately. Our review of documentation and interviews with senior leaders confirmed this. Where areas for improvement were identified, senior leaders took action to address these. For example, before our inspection, the trust had identified the need to refine their governance structure to include 'cross-cutting' boards that each of the clinical service lines fed in to. This was to ensure there was a route for some shared accountability in specific areas that related to several clinical service lines such as theatres. There were 11 cross cutting-boards including emergency medicine, clinical integration and outpatients. Our interviews with senior leaders confirmed the trust was aware of the potential for duplication in meetings. Senior leaders told us the merger and pandemic had brought unique challenges to ensuring there was sufficient oversight and assurance from ward to board and they would continue to review governance processes as the organisation continued to develop.

Arrangements were in place to govern and manage arrangements with third party providers and other partners in care. The trust was involved in the evolving system-wide governance as part of the ICB. The chief executive officer (CEO) and Chairperson attended meetings with other senior leaders in the Bedford, Luton and Milton Keynes system to develop the shared accountability and governance required across the system. During the core service inspections, we found staff at all levels were generally clear about their roles and understood what they were accountable for.

Medicines optimisation was reported at board level through specialist committee oversight board. Both sites had a medicines safety officer to review medicines incidents and the strategy highlighted the need for joint working. However, due to pharmacy staffing issues the pharmacy team did not have a governance team to monitor quality outputs.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were comprehensive assurance processes in place and performance issues were escalated appropriately through clear structures and processes.

The trust identified and escalated relevant risks and issues and identified actions to reduce their impact. The trust had a corporate risk register which contained the board level risks. Each clinical service line would review their risks and rate them using a specific matrix. The trust had a risk review group which consisted of the deputy CEO, chief nurse and director of quality and safety governance. This group reviewed each clinical service line's risk and identified if they met the threshold for escalation to the corporate risk register.

There were processes to manage current and future performance. This included clinical service lines attending regular performance reviews with executive team members. Leaders at all levels attended system-wide meetings to discuss the trust's performance within the ICS and to develop future performance models.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes.

Our findings

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. This included incident reporting systems and clinical service line risk registers.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand.

When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored. Whilst there were no examples of where financial pressures had compromised care, this was a potential risk. The capital programme did not prioritise essential maintenance such as fire safety and during the core service inspections we found a number of fire safety hazards at both locations which had not been identified or escalated. The trust took immediate actions to address the safety concerns. Our interviews with senior leaders and review of documentation demonstrated there were no clear prioritisation criteria that had been approved by the board and committees to demonstrate essential schemes such as fire safety received sufficient priority.

There was an audit programme in place to monitor medicines optimisation processes, however this was still being embedded with some, including antimicrobial audits, still in their infancy. A high vacancy rate of 30% resulted in gaps in clinical pharmacy support in areas such as paediatrics and maternity services. Medicines risks were part of the trust register, however due to the lack of a governance team within pharmacy this had not been reviewed.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required. The information systems were secure but not yet integrated across the trust.

There was a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. Information was used to measure for improvement, not just assurance.

The trust reviewed the effectiveness of information received at board. At the time of our inspection, papers and reports for committees were being reviewed to ensure they were effective and efficient.

Quality and sustainability received sufficient coverage in relevant meetings at all levels. The trust used a range of performance indicators and used statistical process control analysis and identified special cause variation. Senior leaders told us they had sufficient access to information, and they challenged it appropriately.

There were clear service performance measures which were reported and monitored in various forums. There were effective arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.

The trust had an IT strategy to develop the integrated information systems across both locations. The trust was also involved in the system-wide planning to align data systems.

There were effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

Our findings

Arrangements were in place (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. People who used services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture.

Senior leaders worked hard to ensure staff were actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture. This included those with a protected equality characteristic.

Senior leaders in the trust had started building positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs.

The trust had a plan to engage with all stakeholders in relation to the recently developed formal strategy.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had an understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

The trust did not use a standardised quality improvement methodology. Senior leaders told us staff were encouraged and supported to make suggestions and improvement and gave examples of ideas which had been implemented.

There were organisational systems to support improvement and innovation work.

Staff were receiving training in improvement methodologies to use standard tools and methods.

Effective systems were in place to identify and learn from unanticipated deaths.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. The trust had recently recruited cross-sector pharmacists who had a split role between the trust and general practice. This resource was targeted at general practices with the largest numbers of patients admitted to the trust. The aim of this role was to provide oversight on medicines needs from admission to hospital to discharge to the community.

During our core service inspections, junior doctors spoke positively about their learning experience at BHFT. This was positive as up until September 2022 the trust had been under enhanced monitoring from Health Education England. This status was formally upgraded to normal monitoring in October 2022 due to the improvements made for doctors in training.

Our findings

The trust had been a part of the pilot for the new emergency care standards.

Despite the challenges in demand, the trust took part in clinical research.

Notes on ratings tables on the following pages

In the table on page 15-16 headed 'Ratings for acute services/acute trust', the overall trust ratings in the bottom row do NOT take into account ratings for Bedford Hospital that come from when those hospitals were managed by a different trust.

The overall rating for well-led comes from our inspection of trust wide leadership rather than an aggregation of well-led at service level.

The ratings tables on page 17 for Bedford Hospital show ratings from this inspection and when they were managed by a different trust. We have not rated the hospital overall at this inspection. For more information, please see the explanation at the start of the Overall summary on page 2.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good ↓ Dec 2022	Good →← Dec 2022	Good →← Dec 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Luton and Dunstable Hospital	Requires Improvement →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good ↓ Dec 2022	Good ↓ Dec 2022	Good →← Dec 2022
Bedford Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good ↓ Dec 2022	Good →← Dec 2022	Good →← Dec 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Luton and Dunstable Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022
Services for children & young people	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Outstanding Dec 2018	Good Dec 2018
Critical care	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
End of life care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Maternity and gynaecology	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Surgery	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Urgent and emergency services	Requires Improvement ↓ Dec 2022	Good Jun 2016	Good Jun 2016	Good ↓ Dec 2022	Good ↓ Dec 2022	Good ↓ Dec 2022
Maternity	Requires Improvement Dec 2022	Good Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022
Overall	Requires Improvement →← Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good ↓ Dec 2022	Good ↓ Dec 2022	Good →← Dec 2022

Rating for Bedford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement ↑ Dec 2022	Requires improvement Jan 2021	Good Dec 2018	Not rated	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022
Urgent and emergency services	Requires Improvement Dec 2022	Not rated	Not rated	Requires Improvement Dec 2022	Not rated	Not rated
Medical care (including older people's care)	Requires Improvement Dec 2022	Good Dec 2022	Good Dec 2022	Good Dec 2022	Requires Improvement Dec 2022	Requires Improvement Dec 2022
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Bedford Hospital

South Wing
Kempston Road
Bedford
MK42 9DJ
Tel: 01234792100
www.bedfordhospital.nhs.uk

Urgent and emergency services

Inspected but not rated

Is the service safe?

Requires Improvement ➔➔

This is the first time this service has been rated. We rated safe as Requires Improvement.

Mandatory training

The service provided mandatory training in key skills not all medical staff had completed it.

Nursing staff received and kept up to date with their mandatory training. The service set a 90% compliance target for all mandatory training, and nursing staff achieved 94% compliance overall. Medical staff did not meet the service's 90% compliance target, achieving 69% compliance overall due to pressures within the service. The service has made a commitment to ensuring 100% of its staff team complete mandatory training by December 2022.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included but was not limited to equality and diversity, fire and health and safety, infection control, information governance, and moving and handling amongst others.

Clinical and nursing staff completed training on recognising and responding to patients with dementia, medical staff achieved 73% with dementia tier one and 66% with dementia tier two. Nursing staff achieved 94% with dementia tier one and 66% with dementia tier two.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with explained how the electronic staff training record was maintained and how the system showed when training was due or overdue. Managers monitored training compliance and the service had employed additional staff to support staff development and improve training compliance.

Safeguarding

Staff understood how to protect patients from abuse, however not all staff had received training.

Nursing staff received training specific for their role on how to recognise and report abuse. Data supplied by the service following our inspection showed nursing staff achieved 100% compliance with safeguarding children training level 1, 99% compliance with level 2, and 70% compliance with level 3, the remaining staff were due to complete training before the end of 2022. Nursing staff achieved 100% compliance with safeguarding adults' level 1, 97% level 2 and 76% level 3. Plans were in place for staff to complete part two of the course safeguarding adults' level 3 virtually over the coming months.

Medical staff mostly received training specific for their role on how to recognise and report abuse. Data supplied by the service following our inspection showed medical staff achieved 84% compliance with safeguarding children training level 2 and 72% with level 3. Medical staff achieved 76% compliance with safeguarding adults' level 2 and 56% level 3. Plans were in place to improve medical staff compliance with safeguarding training.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff we spoke with clearly explained how they placed patients at the centre of the safeguarding process and were clear on their roles and responsibilities. The service had up-to-date policies for safeguarding adults and children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff we spoke with explained the processes in place to identify frequent attenders, and unexplained injuries, especially in children. Staff training included guidance on the types and signs of abuse, including domestic violence, female genital mutilation, unexplained injuries and staff were able to give examples when they had made referrals, such as unexplained injuries in children or children on the at-risk register with the local authority.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The referral process for safeguarding children concerns was comprehensive and staff had to complete a number of key questions prior to submitting the referral to ensure they had thoroughly captured the child's needs and any concerns. Staff explained the process for making a safeguarding adult referral, and flow charts, safeguarding staff contact details and staff photos were displayed throughout the ED to enable staff to identify and make safeguarding referrals to the correct teams.

Staff followed safe procedures for children visiting the ward. At the time of our inspection patients could bring one relative or carer with them due to restrictions in the COVID-19 pandemic visiting guidance. Children were only allowed in the children's ED once they had been streamed or triaged in main reception. Children were not allowed to wait in the main ED reception and contact between adult and child patients was restricted.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness and infection prevention and control (IPC) audit data showed 100% compliance against the services environmental and equipment cleaning activities in June 2022.

Records we reviewed showed that cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Data from the services IPC audits showed 100% compliance with the use of PPE and hand hygiene. Staff we spoke with knew the services IPC processes. The services IPC policy was up-to-date, and there was additional guidance around the departments in relation to infection control, including COVID-19. Staff had access to a wide range of personal protective equipment, handwashing facilities, sanitisers and antibacterial wipes. Hand sanitisers were readily available throughout the location, and staff used hand gel and sanitisers before and after every episode of direct patient contact or care. This was in line with *NICE guideline QS61 Statement 3 (2014), Infection prevention and control - Hand decontamination.*

At the time of our inspection, the staff were following the service's COVID-19 processes. All patients arriving at the ED were asked if they had any COVID-19 symptoms. Patients entering the ED with suspected COVID-19 were placed in dedicated sealed and restricted bays until they had completed a COVID-19 Lateral Flow Test (LFT). Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We noted during our inspection that staff used appropriate cleaning materials when wiping down equipment between each patient use, for example antibacterial wipes. Domestic staff were proactively engaged in cleaning activities, including ensuring cubicles were cleaned between patient use. Domestic staff followed a daily rota with defined areas to complete during their shift and data from June 2022, showed staff had completed all the necessary cleaning activities.

Nursing staff achieved 100% compliance with level 1 IPC training and 78% with level 2, however medical staff only achieved 48% compliance with level 2.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We noted that patients could access call bells and that staff responded to this promptly during our inspection.

The design of the environment followed national guidance. The service had made significant improvements within the children's ED since our last inspection, this had dedicated security access control with CCTV and swipe systems in place. Adults and children once initially booked into the main reception area did not mix with adult patients.

Two rooms in the children's ED dedicated to isolation (Red) areas for COVID-19 were not in direct site of the nurse's station and behind an additional safety door. This would mean if this area was in use a staff member would have to be deployed to this area at all times as there was no central patient monitoring system and it was out of line of sight from the nurse's station. This was on the services risk register and staff were aware and mitigated the risk by providing one to one staff support in this area when needed.

Following our last inspection, the service had improved its facilities for the support of patients who may attend the adult ED with additional mental health needs. A new room with a panic strip on all walls, egress and exit routes, weighted chairs, anti-ligature handles and sealed blinds within the door for viewing had been built within the adult ED away from any children's services. Staff had completed appropriate up-to-date ligature assessments for the ED environment. This was a significant improvement from our last inspection and in line with the *Royal College of Emergency Medicine, Mental Health in Emergency Departments – a tool kit for improving care (April 2021)*. There were no similar arrangements in the children's ED nor a dedicated cubicle for any child who may attend with additional mental health needs. Staff did say they could use one of the rooms in the children's ED or refer them directly to the children's ward, but the patient would need direct supervision at all times whilst staff called for the child and adolescent mental health services team (CAMHS) or the service's on-call psych teams. Given the rise in young people attending ED post COVID and self-harm / eating disorders this would be something the service should consider going forward in terms of providing a safe place for young people attending the ED.

At our last inspection we told the service that it must ensure staff carried out checks on emergency equipment and had a system in place for ensuring this was completed. Staff carried out daily safety checks of specialist equipment and the services had implemented a series of quality checks and audits to maintain oversight of staff compliance. During our inspection we checked three resus trolleys (three checked for audits, one had a complete check). We opened one resus trolley in ED majors, and completed a full check and found no irregularities. Quality check and audit records we reviewed showed staff completed daily and weekly audits in line with the services guidance.

Urgent and emergency services

We reviewed the paediatric resus trolley and found some gaps in the daily checks, but weekly and daily checks were largely complete. We checked the resus trolley in the corridor outside of the isolation weekly and daily checks were complete.

The service had suitable facilities to meet the needs of patients' families. The ED had dedicated waiting areas for major and minor ambulatory patients attending, and while the ED was exceptionally busy on the day of our inspection, waiting areas were not overcrowded and no patients were waiting outside the ED or in corridors.

At our last inspection we told the service that it should ensure privacy and dignity was promoted when booking into the emergency departments. We found that the service had improved its reception areas and observed staff promoting privacy and dignity when booking patients into the department. Staff would take patients who may have sensitive issues or not wish to speak in the main reception into one of the triage rooms or another private area to get their details.

The children's ED provided a range of activities and toys to engage children in age-appropriate activities. Children could be seen from the nurse's station and no one could leave the area without staff activating the security systems. The adult ED had a room with appropriate furnishings that was private and had a small outdoor area for use by relatives who may need a private space.

The service had enough suitable equipment to help them to safely care for patients. During our inspection we noted staff had access to a wide range of appropriate equipment to enable them to treat and care for patients. Equipment and consumables were stored appropriately, and corridors were not crowded. There were systems in place to ensure the regular maintenance of equipment took place and equipment was within its service renewal date.

Staff disposed of clinical waste safely. Staff ensured clinical and domestic waste bins were segregated and sharps bins appropriately dated and signed.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Patients arriving by ambulance used a dedicated ambulance entrance for both adults and children. Adults would then proceed to the ED assessment and treatment areas, majors or minors, or resus areas. Children would either be taken into a resus area within the adult ED that was used for adults and children or into the children's ED. Patients arriving on foot reported to the services main ED reception.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score system (NEWS2) for adults and paediatric early warning scores (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs of respiratory rate, oxygen saturation, temperature, blood pressure, pulse and heart rate. We reviewed seven sets of adult patient records and three sets of children's patient records which showed staff had fully recorded patient NEWS and PEWS. Staff monitored NEWS and PEWS using an electronic patient information system, which highlighted when the scores increased, staff would then take appropriate escalation action to manage the patient's condition.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a recognised process when completing initial patient assessments.

Urgent and emergency services

During our inspection we reviewed the initial triage times for seven adults and three children. Patient records showed five of the adults and all the children were triaged within 15 minutes of arrival by ambulance and streamed to the appropriate area within the ED. Staff could monitor waiting times directly from the electronic patient record and escalate patients who were waiting too long to be seen.

Data provided by the service following inspection showed that from August 2021 to February 2022, the service routinely triaged less than 20% of its adult patients within 15 minutes. During the same period the service triaged between 28.53% and 43.44% of paediatrics within 15 minutes. Between March and July 2022, performance against the 15-minute triage for adults declined from 22.47% to 15.18% and paediatrics achieved between 33.46% and 40.58% during the same period. Triage times were in the main affected by patient flow, and staffing levels, however staff were aware of an monitored triage times to ensure any paints likely to deteriorate were managed appropriately.

Data supplied by the service following our inspection showed compliance against the 15-minute triage target for adult patients remained consistently below 43% during the twelve months before our inspection. Compliance against the 15-minute triage for paediatric patients declined monthly from 56% in February 2021, to 25% in February 2022.

The service had made improvements to its environment for supporting patients with additional mental health needs and implemented a dedicated mental health triage process to identify and provide additional support to patients who may be at increased risk, for example due to self-harm or a medicine overdose. Staff we spoke with knew how to complete the mental health triage process and had access to appropriate mental health services for adults and children either on site from mental health teams or by using dedicated mental health on call systems.

The service had an up-to-date policy and processes for managing the deteriorating patient. The service did not cohort patients in corridors during times of high patient flow. Escalation processes were in place to identify patients at risk of deterioration including any patients waiting on ambulances for extended periods. If staff were unable to offload ambulances immediately staff utilised the ambulance delay escalation tool and ambulance action cards to ensure patients were monitored for deterioration and assessed timely by a clinician.

Staff knew about and dealt with any specific risk issues. The service had an up-to-date process for the management of upper gastrointestinal haemorrhage (UGI) in adults. Staff we spoke with knew how to identify sepsis and how to implement the sepsis six care bundle. We noted an example of where staff had escalated a patient with suspected sepsis in line with the sepsis guidance. Data supplied by the service following inspection showed that in January, February and March 2022, staff achieved 100% compliance with screening for paediatric sepsis and 100% of patients who required IV antibiotics received this within an hour. This complied with the *National Institute for Health and Care Excellence (NICE) Quality statement 2: Senior review and antibiotic treatment.* During the same period staff achieved 100% compliance with screening for adult sepsis and 89% of patients who required IV antibiotics received this within an hour. The service had a proactive process for supporting patients with neutropenic sepsis. Patients at risk of neutropenic sepsis carried a red card which they produced on entering the ED to speed up prescription and care processes. In June 2022, staff achieved 85% compliance against the one-hour target for IV antibiotics.

Leaders told us that as part of staff planning, there was always a staff member on duty with the appropriate lifesaving training competencies and training. Data supplied by the service following our inspection showed that 84.75% of all ED nursing staff had completed paediatric immediate life support, 66% of children's nurses had completed the European paediatric advanced life support (EPALS) (four out of six), there were an additional seven registered nurses who had completed EPALS. Nursing staff achieved 83% compliance with immediate life support and advance life support. This included training in sepsis recognition and treatment, completion and management of NEWS and PEWS. Nursing staff

achieved 87% compliance with adult resus level 2 and 80% compliance with paediatric resus level 2. Medical staff achieved 40% compliance with adult resus level 2 and 45% compliance with paediatric resus level 2. The service told us that the ED had a lot of new staff and the experienced staff with the trauma qualification had left and they were actively seeking to train the new staff as courses became available.

ED reception staff did not complete first aid training however the service told us that the practice development nurse was liaising with the services education team to run a first aid training course. Staff could see all patients within the ED reception and had access to an emergency call bell, medical and nursing staff within close proximity and emergency equipment was available in the services triage rooms close to the ED reception.

The service was focusing on reducing patient falls within the ED and we noted that falls risks was a new addition to the patient record, which was yet to be audited for its impact and effectiveness. The medical staff could also screen patients aged over 65 for the frailty service. However, within the records we reviewed we noted one falls risk assessment hadn't been completed for a patient and the medical team had missed three opportunities to complete the patient frailty risk assessment.

Where patient required on going observation for pressure care, staff had completed the necessary risk assessments and transferred the patient to pressure relieving mattresses for comfort and safety.

Staff shared key information to keep patients safe when handing over their care to others. This was done by using a blend of written and electronic patient records.

Shift changes and handovers included all necessary key information to keep patients safe. We observed staff handovers and found these to be focused on patient safety and well-being. Staff shared key information on care and treatment plans, medication, risks and plans for admission or discharge where appropriate.

Staffing

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The number of nurses and healthcare assistants matched the planned numbers and the service had enough nursing and support staff to keep patients safe. At the time of our inspection, actual nurse staffing levels met planned levels. The later nursing shift had reduced staffing due to staff sickness, but the manger had plans in place to cover the shortfall. The service had systems in place to plan and review its nursing workforce and escalation processes to deal with any short-term absences. Leaders had remodelled the nurse staffing roster in response to increasing patient activity and the increase of patients in the ED early in the morning. Leaders told us that the new staff roster was more aligned to patient activity and bed pressures within the service to make best use of staff across 24 hours.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders held an 8.15 am meeting daily in the ED, which included staffing resources and the matron attended the 9.30 am staffing meeting to cover and mitigate any gaps in the staffing rota and gain help from across the service where appropriate.

The department manager could adjust staffing levels daily according to the needs of patients. The service planned work force rotas in advance and used the ED situation reports to escalate any concerns regarding staffing levels to the site team and drew on the service's wider resources. The ED leadership team completed the safer nursing care tool in May 2022, to identify any shortfalls and this was due to be repeated in the next twelve months.

The service had reducing vacancy rates. Data supplied by the service following our inspection showed that between August 2021 and June 2022, vacancy rates fell from 22.11% to 12.83%, slightly increasing to 14.44% in July 2022.

The service had increasing turnover rates. Data supplied by the service following our inspection showed that between August 2021 and July 2022 vacancy rates increased from 17.82% to 20.56%. The service recognised that retention had been challenging, in part due to the impact of the COVID-19 pandemic and had plans in place to recruit new nurses into the work force and upskill additional health care staff. Leaders were actively encouraging student nurses to return to the ED following their training placements and increasing their presence on social media to attract new recruits.

The service had reducing sickness rates. Data supplied by the service following our inspection showed that sickness rates increased between August 2021 and November 2021, from 7.04% to 11.24%. However, sickness rates then reduced from 8.19% in December 2021 to 6.13% in July 2022. Leaders discussed sickness trends and mitigations taken as part of the services overarching governance processes.

The service had low rates of agency nurses. Data supplied by the service following our inspection showed that between July 2021 and July 2022, the use of agency nursing staff was routinely below 2%. During the same period the use of bank nursing staff was between 10% and 11.8%, managers did aim to limit their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

In June 2018 the *Royal College of Paediatric and Child Health (RCPCH) published Facing the Future: Standards for children in emergency care settings*, developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. The guidance included 70 standards across a range of areas including: integrated emergency care systems, the environment, workforce and training, management of treatment and care, safeguarding, mental health, complex needs, safe transfers, death of a child, information systems and research. Recommendation 10 states that every emergency department treating children must be staffed by two registered children's nurses.

Staff we spoke with in the children's ED told us there were not always two registered children's nurses (RCNs) on duty in the children's ED. Staff we spoke with told us ongoing recruitment was in place, but recruitment to the RCN roles had been challenging. The lack of two qualified RCN was on the services risk register and the team covered paediatric shifts through support from registered general nurses (RGNs) who had completed paediatric competencies and were paediatric immediate lifesaving trained as part of the service's escalation processes.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

Medical cover was arranged across both the adult and paediatric ED. At the time of our inspection the service had enough medical staff to keep patients safe and medical staff matched the planned number.

Urgent and emergency services

The service had low vacancy rates for medical staff. Between August and November 2021, vacancy rates for medical staff ranged 5.02% to 7.93%, they increased to 10. 26% in December 2021 and January 2022. Vacancy rates then reduced, remaining below 7.17% between February and May 2022, falling to 5.26% in June 2022. There was an increase to 10.02% in July 2022, but this was due to natural changes in staff teams and was in line with previous vacancy rates within the service.

Between August 2021 and July 2022, the turnover rate for medical staff was between 11.09% and 13.04%. Leaders had appropriate recruitment processes in place and monitored staff turnover rates to look for any trends. Data supplied by the service following our inspection showed that medical staff turnover rates remained consistent throughout the 11 months prior to our inspection with no significant concerns.

Sickness rates for medical staff were low between August 2021 and July 2022. Data supplied by the service following our inspection showed sickness rates were routinely below 4%.

Managers could access locums when they needed additional medical staff. Data supplied by the service following our inspection showed the service used a consistent level of agency and bank staff. Between August 2021 and July 2022 agency use was routinely below 4.3%. Bank staff usage was higher during the same period ranging between 11.5% and 18.7%.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. Consultant cover was on site from 7.30am to 11.30pm seven days a week. Outside of this time, there was always a minimum of two tier four medical practitioners assigned to the ED, following the services workforce matrix.

In June 2018 the Royal College of Paediatric and Child Health (RCPCH) published Facing the Future: Standards for children in emergency care settings, developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. The guidance included 70 standards across a range of areas including: integrated emergency care systems, the environment, workforce and training, management of treatment and care, safeguarding, mental health, complex needs, safe transfers, death of a child, information systems and research. Recommendation 9 states every emergency department treating children must be staffed with a paediatric emergency medicine (PEM) consultant with dedicated session time allocated to paediatrics, the service did not meet this recommendation. However, leaders were actively trying to recruit staff to meet this recommendation.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Leaders use the services work force matrix to ensure that staffing levels and competencies met patient acuity and patient flow levels through the ED.

From August 2022, the leadership team will be introducing a seven-day emergency medicine assistance care practitioner rota to complement the medical workforce rota.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used a blend of electronic and paper-based records. We reviewed seven sets of adult patient records and three sets of child patient records. These were accurate, legible, up-to-date and identified the named professionals in charge of the patients care. However, within the records we reviewed we noted one falls risk assessment hadn't been completed for an adult patient and the medical team had missed three opportunities to complete the adult patient frailty risk assessment.

When patients transferred to a new team, there were no delays in staff accessing their records. As some of the patient records were electronic, this enabled a wide range of appropriate professional staff to review and update patient records.

Records were stored securely. IT systems were password protected ensuring no unauthorised staff could access the system to view patient records. Paper records that required immediate access were stored behind nursing stations in clear wall pockets for easy access, but still out of reach of unauthorised persons.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, recording and storing medicines. Staff were aware of protocols for sepsis and daily audits showed that these were followed. Daily audits also showed that patients were able to access pain control when needed.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We noted evidence of long stay care plans which were initiated after a patient had been in the department for four hours and were due to be admitted which included prescribing and administration of regular medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines storage cabinets in the main clinic room were not locked as per the medicines policy. However, the service was aware of this and a risk assessment had been made around access to urgent medicines. The pharmacy department were in the process of sourcing an electronic medicines cupboard for the ED department to increase security whilst maintaining timely access to urgent medicines.

Staff followed current national practice/guidance to check patients had the correct medicines. The ED department did not have a pharmacist based in the department; however, staff were able to contact support from pharmacy when needed, this included out of hours.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The pharmacy department provided a monthly bulletin which contained medicines information and safety tips. Urgent updates were distributed by an email cascade to ward managers who then passed this information onto their staff by email and staff briefings. There was also a safety board in the department which contained key information about medicines including administration guidance and critical medicines.

Incidents

Urgent and emergency services

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with told us they knew how to report incidents through the service's electronic incident reporting process which was accessible from IT stations within the department.

Staff raised concerns and reported incidents and near misses in line with services policy.

The service had reported no never events in the twelve months prior to our inspection.

Staff received feedback from investigation of incidents, both internal and external to the service. The service had established processes for sharing feedback from incidents amongst the staff team. Managers used dedicated incident newsletters and the monthly ED matrons' message to share information and feedback from incidents. We reviewed the ED matrons' message from July 2022, this covered hot topics in relation to incidents, for example the importance of identifying risks in relation to pressure care and malnutrition to prevent patient harm. The ED incident newsletter, from June 2022, shared information on recurrent incident theses, how to reduce incidents and patient harm

Staff reported serious incidents clearly and in line with the service's policy. From August 2021 to August 2022, the service reported 1,018 incidents within the ED. Of these 412 were low harm, 40 were moderate, one was severe, 498 were no harm, 61 were none clinical and six were in relation to deaths that had occurred within the ED. The service reviewed all incidents as part of its clinical harm review process.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Incident feedback to staff included lessons learnt and changes made to minimise future incidents. We reviewed an example of a patient fall in July 2022, where staff were involved in the investigation and actions taken to reduce additional falls in the department, including advice to all staff on updating patient falls risk assessments.

Managers ensured that actions from patient safety alerts were implemented and monitored. Details regarding safety alerts were shared at team huddles, in matrons' messages and team meetings.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Urgent and emergency services

Managers supported staff to develop through yearly, constructive appraisals of their work. At our last inspection we told the service that it must improve appraisal rates across the emergency department (ED). At the time of our inspection the service had achieved 91% compliance with nursing staff appraisal, and 99% for medical staff against the target 90% compliance target set by the service. This was a significant improvement from our last inspection.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with said the leadership team was focused on improving training and appraisals in order to improve patient outcomes, the patient experience and patient safety.

The service had a practice development nurse and practice development educator in post to support the learning and development needs of staff. Staff we spoke with told us this had been a positive development within the department and that the two roles were always willing to support staff, implement new ideas and support staff to develop in order to improve the service. We noted during inspection specific subjects, for example falls prevention, pressure care and frailty were key areas where the education team were supporting staff to ensure patients received appropriate care and treatment and reduce risks.

Managers told us that all new nursing and clinical staff receive clinical supervision from the practice development educator for up to the first 12 months in post.

At our last inspection we said the service should ensure that managers should ensure regular departmental meetings. Managers made sure staff attended team meetings or had access to full notes when they could not attend, and learning was shared from incidents and complaints.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Improvements in appraisal compliance meant that staff had improved opportunities to meet with managers to discuss their training and development needs. Staff we spoke with told us that managers were willing to support their development.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that managers were keen to engage with them during the appraisal process to identify any additional support or training they needed for their respective roles and that the appraisal was not seen as a tick box exercise that had to be done.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Is the service caring?

Inspected but not rated

Compassionate care

Urgent and emergency services

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Throughout our inspection we observed staff engaged in positive and respectful conversations with the patients and their relatives. Staff did virtual knocks on disposable curtains before entering cubicles, introduced themselves, explained who they were and what activities they were going to carry out.

We observed two staff supporting an elderly patient, they demonstrated compassion and dignity when caring for the patient, reassuring them they would be ok and explained what they were going to do and how they would promote the patient's dignity during the activity. Another member of staff was supporting a child, they showed kindness and understanding of the patient's condition, reassured the parent and explained what actions were needed to improve the child's condition.

Patients said staff treated them well and with kindness. We spoke with four patients and one relative during our inspection. All of them told us that staff treated them with respect and kindness. The only concerns from patients were in relation to how long they had waited to be seen. One patient told us they had come to the service's emergency department rather than use their local health services as they had been to this service before and found them to be much better than the other service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. During our inspection we observed staff supporting a patient who was extremely distressed and confused. The staff remained professional, non-judgemental and took time to try and engage with the patient, reassure them and provide them with appropriate care, despite the significant verbal challenges from the patient.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with explained they had processes for identifying frequent attenders and how they had worked with other multi-agency staff from the police, local housing and social services staff to provide the patients with appropriate care and signpost them to other services. The service knew that locally there was deprivation and that alcohol and drugs services were in high demand. Delays in other services increased attendances for some patients and staff knew how important it was to liaise with family, friends and other services to provide emotional support and care to vulnerable patient groups.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us that staff had been clear about their treatment and care plans. One patient explained that the service had liaised with their own general practitioner regarding their care to ensure follow ups were in place.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment, and staff supported them to do this. We observed feedback forms and posters around the ED, patients and relatives could also leave feedback on-line by using the service's website.

Is the service responsive?

Requires Improvement 

This is the first time this service is being rated. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Leaders were engaged with patients, relatives, community health services, primary care services, integrated care boards (ICB) and other NHS organisations to adapt emergency department (ED) services. For example, renegotiating general practitioner (GP) services within the ED and increasing opening hours for its urgent treatment centre to stream patients quickly, safely and avoid hospital admissions whilst reducing patient waiting times.

The leadership teams held regular engagement with system partners on a monthly basis. For example, the monthly THINK 111 First Group, reviewed patient cases at monthly clinical review meetings with NHS 111, and held a monthly interface meeting with NHS mental health services to discuss the psychiatric liaison service at Bedford hospital.

Facilities and premises were appropriate for the services being delivered. The service had made improvements to the physical environment in order to manage increased demand and in response to the COVID-19 pandemic.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a rapid response and frailty team who provided urgent assessment of frail older patients coming into the ED. The service ensured patients received appropriate care, including avoiding admission where possible.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

Managers we spoke with explained how they engaged with staff to improve flow and services for people. This was to include looking at external services that could be accessed before admission, pathways on admission and discharge. Leaders were specifically exploring how discharge planning and the use of rapid response in the community could improve flow through the hospital. The service had introduced a silver phone system to support GPs and community staff who could call and speak to frailty staff and get advice prior sending patients into the ED, to consider alternative care pathways and admission avoidance.

Access and flow

Urgent and emergency services

People could not always access the service when they needed it, and waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times. However, due to demand at times, not all patients received treatment within agreed timeframes and national targets.

The service had developed comprehensive systems to monitor wating times between the emergency department (ED) staff team and the service's wider site team. Dedicated staff monitored flow throughout the ED at set times through the day using the service's ED situation report. Managers completed the report and faxed this to the site team office to ensure the wider site was aware of patient flow, any increased risks, for example reaching patient capacity, increased ambulance handover times and increased triage times.

We observed positive working relationships between the staff teams to manage flow, however factors such as bed capacity across the hospital, lack of patient speciality review and delayed discharges impacted on the flow throughout the ED and wider services. A key issue staff raised was the use of internal standards and that there was no consistent performance in terms of patients receiving a speciality review within an hour. Data supplied by the service following our inspection showed that between August 2021 and July 2022, the percentage of patients seen within an hour by a specialist was routinely below 11%. Staff told us that surgical teams were focused on their elective work and did not always meet the internal professional standards to respond to demands within the ED, and there was a lack of focus on the internal standards.

Staff described a culture of inappropriate patient attendances at the ED due to patients being unable to get a general practitioner (GP) or dental appointment. The service saw upwards of 70 patients per day in its minor injury areas. We noted some patients that could have been seen in far less acute settings that were waiting for general treatment for issues such as Eczema, or minor injuries that could be treated at home or by using a minor treatment centre or GP services. Some patients we spoke with told us they attended the ED because they had struggled to get a GP appointment or 111 had directed them their due to lack of resources locally.

Managers and staff worked to make sure patients did not stay longer than they needed to. Managers and staff in the ED started planning each patient's discharge as early as possible, but some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge.

At the time of our inspection, bed occupancy on the medical and surgical wards (the main receiving wards when patients were transferred from the ED) was above 99%. This level of bed occupancy made it difficult to move patients from the ED for admission into the ward areas. Factors such as high bed occupancy, delayed discharges, and waiting for additional clinical review were key factors affecting patient waiting times in the ED.

The Department of Health and Social Care's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. However, in 2018, NHS England began a review into NHS access standards including the four-hour A&E standard. The review proposed replacing the four-hour standard with a new basket of standards, including measures of how long patients wait before assessment or treatment in A&E. The new standards were piloted in 14 NHS services and this service is one of the services piloting the new standards. The service still recorded performance against the 95% standard. Data supplied by the service following our inspection showed that between April 2021 and July 2022 the service did not achieve the 95% standard at any time. Performance ranged from 67.1% in August 2021 to 51.7% in July 2022.

Urgent and emergency services

Data supplied by the service following inspection showed in August 2021, 0.8% of patients waited longer than 12 hours in the ED, this increased monthly to 6.9% in January 2022. Waiting times reduced to 5.66% and 5.51% in February and March 2022 but increased to 8.1% in April 2022. Waiting times reduced again to 5.1% and 5% in May and June, increasingly slightly to 6.2% in July 2022. The service reviewed all patients who had remained in the department longer than 12 hours for any avoidable harm and to consider ways of reducing waiting times in the future.

Between August 2021 and May 2022, the number of patients leaving the service before being seen for treatments ranged between 4.0% and 5.53%. This increased slightly to 6.31% in June 2022, then reduced to 5.74% in July 2022. This was generally better than the England average.

The percentage of ambulances remaining at hospital for more than 60 minutes varied between August 2021 and June 2022. In August 2021, 1.9% of ambulance waited for more than 60 minutes, this increased monthly reaching 8.9% in November 2022. Since December 2021, waiting times had in the main reduced, with data supplied by the service showing 2.54% and 2.62% of ambulances waited over 60 minutes in May and June 2022 respectively. This was better than the England average. During our inspection we noted that ambulance delays were monitored by the ED leadership team in unison with the service's site team to support and manage patient flow. Ambulance staff we spoke with told us that handover delays were infrequent at the hospital and they could pre-alert the service to any patients requiring immediate access to the resus areas. A hospital ambulance liaison officer (HALO) was employed by the local NHS ambulance service and deployed in the service's ED to support ambulance and hospital staff working together to improve and manage patient flow. We noted effective and positive working relationships between the HALO, ambulance staff and ED staff in order to manage patient flow through the ED.

Between July 2021 and June 2022, the percentage of ambulance offloading within 15 minutes was routinely below 50%. However, the service had processes in place to review ambulance waiting times and highlight any patients who may need to be seen more urgently by the medical and nursing team.

Between August 2021 and February 2022, the median time from patient arrival to initial assessment (emergency ambulance cases only) was routinely above 30 minutes but not greater than 35 minutes. The median time reduced monthly from 32 minutes in February 2022, achieving 15 and 12 minutes in April and May 2022. However, times increased again in June and July 2022, to 24 and 30 minutes. This was worse than the England average.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Advice on complaints and how to leave feedback was readily available and displayed around the ED. At the time of our inspection a local patient group was seeking feedback on the service and we noted feedback forms and collection points across the ED.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew the service's complaints process and the importance of managing complaints timely and in line with the service's complaints policy.

Urgent and emergency services

Managers investigated complaints and identified themes. At the time of our inspection, data provided by the service showed that the ED had received 89 complaints in the 12 months prior to our inspection. Thirty-seven of the complaints were not closed in line with the service's complaints time scales, 31 were open at the time of our inspection and 21 had been closed in line with the policy time frames. The service told us that complaints for ED were often part of wider service complaints and therefore, the timeliness for response is not solely reliant on the ED teams.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed at staff handovers and shared in the matron's message and ED incident newsletter to share learning and reduce further complaints of a similar nature.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department (ED) had a clear leadership structure, with defined roles and responsibilities. Staff on duty knew who the emergency physician in charge (EPIC) and nurse in charge was and this was recorded on the staff notice board.

Staff we spoke with told us managers were visible within the department providing day-to-day support and managers worked closely with them to manage patient care. However, staff described the increasing number of attendances as challenging and that despite the leadership intervention, patients were still waiting long periods within the ED rather than being treated, admitted or being discharged.

Leaders supported staff to develop their skills and knowledge and the service had employed additional learning and development staff within the ED to work alongside leaders to offer a range of development and training opportunities to the staff team.

Vision and Strategy

The service had a vision for what it wanted to achieve focused on sustainability of services and aligned to local plans within the wider health economy.

All of the staff we spoke with knew the service's values of teamwork, honesty and openness, respect, inclusivity, valuing people and excellence, staff called these values THRIVE.

Leaders we spoke with explained the service's future vision was to be seen as an example of excellence, that all patients needing treatment in one hour received it, to be responsive to surges in the service, meet clinical standards, provide excellence in education and training, staff satisfaction and opportunities to grow and develop, work across professional boundaries with a multidisciplinary approach to urgent and emergency care in each clinical service line's strategy.

Urgent and emergency services

Leaders understood the challenges within the service and were actively working with partners and external providers to develop the services to achieve its vision. The service had a clinical strategy framework, which leaders and mangers were implementing to make changes within the service, increase capacity and improve the responsiveness of its urgent and emergency care services.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

During our inspection the ED team described working at full capacity, and that it was challenging due to the demands within the department. Staff told us they felt valued by local leadership, they felt the leadership team were trying their best, and that in the main teams worked well together to support patients.

Staff described a family feel, and it was a great place to work, where everyone worked together and supported each other at times of need. The COVID-19 pandemic had seen them working differently and they wanted to encourage more cross-service and multidisciplinary team working to achieve positive outcomes for patients and their relatives.

Specialties were not routinely visiting the ED in line with internal professional standards. The ED leadership team were aware of this and engaging with the other specialist teams to try and improve performance. This placed additional pressure on staff within the ED, which meant staff took longer term ownership of patient care, when patient numbers attending the department increased. This created a culture where staff felt overwhelmed at times due to the demands within the department.

We spoke with key staff regarding patient flow and how resources were deployed, including the management of discharges and bed moves. It was clear that all staff were committed and focused on providing patients with appropriate care, but capacity and flow affected their ability to provide the service they wanted to offer.

Patients could leave feedback in several ways, completing feedback forms and placing these in dedicated feedback boxes, local and national patient surveys, friends and family tests, through the patient advice and liaisons service (PALS) and by social media.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Escalation plans had been brought into effect to manage the COVID-19 pandemic. The service used a multi-disciplinary approach to managing key challenges within the ED. This included the management of flow using combined operational and clinical meetings with divisional teams to address key issues, for example, staffing levels, escalation and risk through its ED situation reports and working closely with the site teams.

The service had comprehensive processes and staff groups for managing governance and took a ward to board approach towards governance and risk. Several groups provided information on governance and risk to the wider teams on issues such as risk and performance. The service held monthly clinical service line meetings covering the ED, which covered key areas of performance and risk including safety and quality, the patient experience, operational performance, finance and workforce.

The service had a comprehensive audit schedule in place and provided data on performance both locally and nationally in relation to patient outcomes, safety and performance. For example, participation in Royal College of Emergency Medicine (RCEM) audits and projects, local audits on patient safety, infection, prevention and control, amongst others.

Bi-monthly executive performance reviews provided assurance and accountability to the service's executive team and was an opportunity to escalate issues for discussion, highlight items for decisions, share good practice and provide information to update.

The service's clinical audit and effectiveness committee met quarterly and was a cross-site meeting that provided updates on positives, negatives and risks for the clinical service line (CSL) prior to inclusion and escalation in the corporate governance and clinical quality operational board (CQUOB) reports. In addition, examples of national and local quality improvement schemes were shared to aid learning from outcomes and improvement ideas. We reviewed governance meeting minutes from the CSL relating to May, June and July 2022. These demonstrated that leaders discussed current themes and trends in relation to themes on patient harm complaints and compliments, the service's risk register, work force risks and other key governance issues.

A number of other key groups fed into the series governance processes, including the emergency surgery board, emergency medicine board, children's board, urgent treatment centre clinical governance meeting and transfusion committee.

The service was engaged with the emergency care intensive support team (ECIST), among others, to support the team to make sustainable performance improvements in the ED.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams used systems to manage performance. Staff we spoke with could describe the process for escalating concerns around capacity and risks within the ED. The service had robust arrangements for identifying, recording and managing risks and mitigating actions. Staff knew the highest risks within the department which included but weren't limited to patient flow, waiting times, staffing levels and ambulance delays. The service had an up-to-date business continuity plan and major incident plan to provide continuity of services during any major business disruption and respond to any major incidents.

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact.Managers we spoke with described in detail the risks within the service and how staff were encouraged to report any risks or concerns to the manager in charge or by using the service incident management processes. The risks staff described to us during

inspection were recorded on the ED service risk register. All risks had risk owners assigned, detailed the mitigating actions in place to reduce risks and risks had been reviewed regularly. We noted minutes from the service's trauma committee in July 2022, which demonstrated that leaders reviewed key risks, incidents and performance in order to make improvements within the service.

The emergency department incident newsletter contained updates on risks, a copy of the ED risk register, and recurrent themes impacting on risk and performance. Staff were encouraged to talk about risk, and reporting incidents in a "Just culture". The service had systems for reviewing incidents called an after-action review, which encouraged open dialogue and a no blame culture when reviewing and learning from incidents to reduce risks.

Managers monitored performance of the service using a programme of internal and external audit. Staff we spoke with told us audit data was shared at team meetings, during staff handovers and team briefings and from feedback by email.

Staff could access ED performance data at the site office, and patient waiting times and discharge plans could be identified in the patient records at any IT workstation in the ED. We discussed data and performance sharing processes regarding patient flow with leaders within the service. The service was using IT-based systems to help plan and manage resources for patients, including predicting demand and staffing levels. However, we noted that there was a lack of visual prompts and centralised data within the ED which staff could have utilised during safety huddles, staff handovers or board rounds to focus on flow, performance and risk. There was a white board which was titled performance data, but this was empty and not in shared central area of the ED. There was a real opportunity to expand some of the embedded patient flow work between the ED team and the site teams around performance and encourage all staff to take ownership of performance.

The service considered potential risks when planning services and considered alternative care pathways to address changes in demand, for example retendering for general practitioner (GP) services and increasing hours within the urgent treatment centre.

Escalation processes were embedded within the service to deal with increased demand, the challenge of the wider hospital capacity issues and the impact of delayed waits on patients was a concern for the ED service.

All patient deaths were reviewed by the service's medical examiner, structured judgement reviews were shared with the team to share learning and the service was in the process of developing cross-site mortality and morbidity to ensure all staff members were included.

Engagement

Leaders actively and openly engaged with staff.

At our last inspection we told the service that it should ensure there were regular departmental meetings. The service had implemented a number of staff meetings that reflected the needs of the various staff groups within the ED to ensure information was shared, including learning form incidents, updating them on service wide activities, risks, performance and wellbeing activities.

Staff told us that they had been able to access additional support during the COVID-19 pandemic and that leaders and managers took staff wellbeing seriously.

Learning, continuous improvement and innovation

Urgent and emergency services

All staff were committed to continually learning and improving services.

Leaders worked with an external provider to improve communication with patients by a text system for any patients booked by NHS 111 to be informed of their arrival time in the ED.

Leaders worked with an external provider to implement the “THINK 111”, a separate minor injuries booking/stream.

The changes to the ED physical environment facilitate patient flow, prioritising good visibility of the waiting areas.

Leaders worked alongside the wider service’s oncology teams to improve the visibility and responsiveness to patients with neutropenic sepsis, and staff have rolled out the patient red card system for early patient intervention and support.

The team have collaborated with inpatient specialities setting up speciality hot clinics (gynae, cardiology) and worked closely with the orthopaedic team in the development of the virtual fracture clinic pathway.

From August 2022, the leadership team will be introducing a seven-day emergency medicine assistance care practitioner rota to complement the medical workforce rota.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

This service had not been inspected before. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, but not everyone had completed it.

Nursing staff did not always receive and keep up to date with their mandatory training. The average total compliance for the core statutory and mandatory training modules was 91% (the trust has a target of 90% compliance for all statutory and mandatory training requirements except information governance which had a 95% target). There were four modules where the compliance target had not been met, which were infection prevention and control level 2 (85%), information governance and data security (92% where target was 95%), moving and handling level two (81%) and adult basic life support (81%).

Medical staff did not always receive and keep up to date with their mandatory training. The trust provided data for core statutory and mandatory training compliance for the medical and dental staff group as of July 2022. This also included emergency medicine. The data showed that the compliance target of 90% (or 95% in the case of information governance) had not been met for medical and dental staff overall for any of the core statutory and mandatory training modules. The average total compliance for all of these modules was 71%. There were some medical groups where compliance across modules was low, which was the chest clinic which had an average total compliance of 50% across all modules, and very low, which was general medicine which had an average total compliance of 31% across modules. However, there were some medical groups which had 100% compliance on all of these modules, which were ambulatory care and neurology, and stroke medicine had an average total compliance across all modules of 90%.

The trust explained that they expected a decline in mandatory training compliance due to COVID-19 and guidance given by NHS Employers to suspend mandatory training during this time. They had a mandatory training recovery action plan to increase compliance over the next 18 months.

The mandatory training was comprehensive and met the needs of patients and staff. The endoscopy department provided mandatory training for staff in a range of subjects to ensure they were knowledgeable about systems and processes within the unit. Staff had training on specific endoscopic equipment from manufacturers' representatives who provided onsite training.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs and dementia and did not complete training on learning disabilities or autism.

Dementia training was part of the advanced statutory and mandatory training. The data we saw showed that the average compliance for dementia tier 1 training was 76% and for tier 2 was 48% for the medical and dental staff group. This included emergency medicine.

The average compliance for dementia training tier 1 was 97% and for tier 2 was 78% for nursing staff.

Learning disabilities and autism was not currently a mandatory requirement. However, the learning disabilities team manager was working with education colleagues to assess how the organisation could provide this training. There was a workbook available on learning disabilities. The trust recognised this as an area for development and improvement.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with during the inspection reported that they received communications about mandatory training that was due and also there was an online area where their mandatory training could be viewed, and which showed training due for completion or requiring updating.

Safeguarding

Staff understood how to protect patients from abuse. However not all staff had training on how to recognise and report abuse.

Nursing staff received training specific for their role on how to recognise and report abuse. Average compliance for safeguarding adults level 2 was 96% and for level 3 was 75%. (Level 3 safeguarding adults was part of the advanced statutory and mandatory training not core training). Compliance for safeguarding children level 2 was 91%.

Medical staff did not always receive training specific for their role on how to recognise and report abuse. Average compliance for safeguarding adults' level 2 was 84%. Average compliance was 72% for safeguarding children level 2, and for safeguarding adults' level 3 was 67% and for safeguarding children level 3 was 74% (level 3 children was in the advanced statutory and mandatory training).

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to explain how to make a safeguarding referral, how to escalate this and were aware of the safeguarding leads in the organisation.

Endoscopy staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. We spoke with endoscopy staff who were able to give an example of when they had followed hospital guidance in referring a member of the public to the safeguarding team.

Compliance with disclosure and barring service (DBS) checks for new starters was 100%.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. They did not always keep equipment and the premises visibly clean. However, staff used personal protective equipment to protect patients, themselves and others from infection.

Ward areas were not always clean. Some of the wards we visited during the inspection were visibly dirty in places and we heard from patients that some of the patient areas, such as toilets, had not been cleaned.

The cleaning records we saw were up-to-date and showed that the corresponding areas were cleaned regularly. We requested cleaning records for medical wards and the service provided the cleaning records of the domestic services

department for 7 of the medical wards covering the period from 31 July to 6 August 2022. These records showed that areas had been cleaned daily. However, there was not always evidence of ad hoc cleaning and during the inspection we saw visible dust in one area that should have been cleaned regularly. We also found a visibly dirty area, or heard from patients about visibly dirty areas, on 2 of the acute medical wards, for which we did not see the cleaning records.

Staff used personal protective equipment (PPE). The staff we saw on the wards we visited during the inspection were wearing PPE when interacting with patients. We saw the result of PPE audits for April, May and June 2022. For all three months the audits showed all medical wards were at 100% compliance for PPE.

Staff generally followed infection control principles. We saw the results of hand hygiene audits which looked at staff observed compliancy, 5 moments of hand hygiene compliance, correct use of soap and water for patients and bare below the elbows compliance for April, May and June 2022. Audits showed the over 95% compliance target was met in most cases, but the required number of observations for the audit had not always been met. For the June 2022 audit, in some cases compliance was below target, and one ward showed 50% compliance for both doctors and the five moments of hand hygiene.

On the acute medicine wards some of the infusion giving sets had been disconnected from patient cannulas and clipped up on the stand but not capped off. This meant that patients could be at increased risk of exposure to infection. This was escalated during our inspection.

There had been zero cases of hospital associated MRSA bacteraemia in the last 6 months and there were 14 total hospital-associated Clostridioides difficile *(C.difficile)* (community-onset and hospital-onset healthcare-associated *C.difficile*) cases during February to July 2022.

In the endoscopy department we observed staff adhering to best practice in the management and decontamination of endoscopes in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes (2016). There were systems to ensure and record the maintenance of water quality. Used scopes were recorded in a logbook with a time, date and patient NHS number and scope use date. A label with this information was added into the patient record to complete the tracking cycle.

We saw evidence of daily and weekly testing reports in line with the NHS guidance HTM 01.06 (WHTM 01.06/V2.0 Compliant Endoscope Decontamination Unit) BS EN5883 parts 1, 2, and 4 BS ENISO 14971:2007. Medical devices and test reports were validated by an independent authorising engineer in decontamination.

All cleaning agents used during the decontamination process in the endoscopy cleaning area were kept in line with Control of Substances Hazardous to Health (COSHH) Regulations 2002, in a locked cupboard in the decontamination room.

Staff mostly cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. On most of the wards we visited equipment had been cleaned and labelled with in date stickers to show it was clean, however some equipment had the previous day's date on it and on some wards (AAU) there was a lack of green 'I am clean' stickers compared to what would usually be seen.

We saw the results of medical equipment cleaning audits for April, May and June. The June audit showed 100% compliance on medical wards, except the cardiac catheter suite which was 67%. The current Infection Prevention Control dashboard dated June 2022 showed there were some wards not compliant with the >90% target rate for L8 guard water flushing for Legionella control.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could not always reach call bells. On some wards we visited patient call bells remained attached to their wall fixtures behind the bed, so were out of reach for patients, and some call bells were out of reach elsewhere within the bed spaces.

The design of the environment followed national guidance. However, on a number of wards there were free standing oxygen cylinders at the side of main thoroughfares. Most of these were empty but at least one still contained oxygen, it is recognised guidance that cylinders should be stored in an appropriate cylinder store.

The endoscopy service had suitable premises and equipment and generally looked after them well. However, during our inspection we saw that patient areas within the endoscopy department were being used to store equipment. For example, oxygen cylinders were stored within patient pre-assessment rooms, this was escalated during our inspection. We were told that the areas where the equipment was stored were not used for patient use however this was not the case at the time of our inspection. Medical gas cylinders should be kept in a purpose-built cylinder store that should allow the cylinders to be kept dry and in a clean condition as suggested in the HTM-02 guidance. Patient recovery areas within the endoscopy department were also used to store equipment such as x-ray gowns and other endoscopy equipment.

The service had systems to ensure access to certain areas were restricted. During our inspection we saw that fire doors were propped open within the endoscopy and AAU departmental areas. Staff told us that they were open to allow access points that were accessible to staff. Recognised health and safety guidance HTM 05-03 suggest that fire doors/exits are shut to ensure fire safety is not compromised.

There was a clear flow of dirty to clean instrumentation within the decontamination area. Used scopes were transported from the endoscopy suite into the washers and then transported to the drying area in a separate room.

Staff carried out daily safety checks of specialist equipment. We saw complete daily logs of checks on suction equipment and defibrillators on the emergency trolley on all the medical wards we visited. On one ward (AAU) this had not been completed for one of the days during the inspection. Staff explained this was a night shift task and it had not been handed over to the incoming day shift that these checks had not been done.

The service did not always have suitable facilities to meet the needs of patients' families. Patients we spoke with during inspection reported that there could be more toilet facilities for relatives as they were required to leave the ward for toilets, and that parking was expensive.

The service did not always have enough suitable equipment to help them to safely care for patients. Some of the electrical devices we saw showed overdue dates for PAT electrical testing. Of those with overdue dates, most had been due the previous month or month before, but one was significantly overdue with a date of August 2021. Staff said that this had been escalated and they had been advised these could continue to be used.

Staff disposed of clinical waste safely. The wards had pedal operated bins that were colour coded according to the type of waste. The bins we tested had operational pedals. The sluice had bins for storage of waste from these bins, which were emptied daily or more frequently according to need.

Due to COVID-19 and the need to reduce the risk of transmission, the waste audits which would normally be done two to three times per year in each ward had been scaled back. However due to the lack of regular waste audits the trust commissioned an external complete Waste Audit, but we did not see the results of this.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score 2 (NEWS2) scoring system to monitor patients and identify those requiring escalation. Staff we spoke with were able to describe how they used the NEWS2 score to monitor and escalate patients and the channels available to them for escalation.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The hospital used a patient admission bundle which included a variety of risk assessments to be completed on admission. We saw that these had been completed in the notes we looked at. The service had a process whereby as part of an overall daily check of patient records, ward managers checked that risk assessments had been completed, and matrons completed a check of a sample of patient records weekly. This meant that incomplete risk assessments would be identified and completed.

The nursing quality dashboard for April to July 2022 showed 100% compliance with completion of the falls risk assessment on admission to the current department. In the majority of cases the dashboard showed that a falls care plan had been completed if a patient had been assessed as being at risk of falls.

On the dashboard, pressure risk assessment completed within 6 hours of admission to the ward, reassessment of the pressure risk assessment and signed interventions showed 100% compliance in most cases. Audits of nutrition and hydration showed that in the majority of cases the medical wards were compliant with completing the Malnutrition Universal Screening Tool (MUST) on admission, scoring MUST accurately, maintaining nutrition and hydration plans and food and drink records, and re-assessing patients.

Staff knew about and dealt with any specific risk issues. The service had a process for reviewing falls. For all falls, a post fall protocol and a multi-disciplinary team approach to patient safety (fall) incidents form was completed. The safety incident form included details of the fall, risk factors for fall, review of falls risk assessments and care plans/bedrail assessments, measures to reduce risk of falling again, duty of candour, post fall treatment, and immediate actions to be done. There was a weekly meeting where falls were reviewed by the multi-disciplinary teams.

The service had a sepsis screening and action tool. We saw the results of sepsis audits for January, February and March 2022 which showed compliances of 100% for sepsis screening and IV antibiotics within one hour. However, 2 of the staff we spoke with were not aware of the formal sepsis screening tool. This was concerning because these staff may be looking after patients who require a sepsis screen.

The service had a VTE risk assessment compliance for the months May, June, July of 99%, 98% and 98% respectively.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). There was a psychiatric liaison service which was available at all times for staff to make referrals to or obtain advice and support.

Medical care (including older people's care)

Shift changes and handovers included all necessary key information to keep patients safe. We saw that handover information included a range of information about patients covering all aspects of their needs. Handovers included diagnosis, relevant past medical history, treatment plans including observations, outstanding investigations and results, infections, resuscitation status, mobility, dietary needs, cultural/religious aspects, night time needs, discharge plan, plan for the day. There were two safety huddles per day, morning and afternoon where staff met to review all the patients.

Nursing staff told us that if there were bank or agency staff starting on late shifts part way through the day, which meant they missed the main morning and evening handovers, they would complete a handover with them.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience. However, managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough nursing and support staff to keep patients safe. Boards displaying staffing numbers on wards showed staff shortages and leaders confirmed that the service was short of nursing staff. For all the boards we saw, there were shifts where actual staff numbers did not meet the required number.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders met twice a day to review nursing staff levels and moved staff around between wards according to patient need. However, they were not always able to deploy the required number of nursing staff due to staff shortages. This meant that we were not assured that staffing could always meet the needs of patients. The service had increased vacancy rates. The data for nursing vacancy rates showed that over the period February to July 2022, vacancy rate had increased to 7.5%.

The service had steady turnover rates. Over the period February to July 2022 turnover rate varied from 12.1% to 13.6% with no trend.

The service had variable sickness rates. Over the period February to July 2022 sickness rates varied between 3.7% and 7.0% with no trend.

The service had variable rates of bank and agency nurses used on the wards. Over the period February to June 2022, use of agency staff varied from 6.3% to 7.7% with no trend. Use of bank staff varied from 9.9% most recently to 14.4% with no trend.

Managers offered bank and agency staff a full induction to ensure they understood the service. Agency and locum staff came with the required training and had a local induction held on the ward. Bank staff were offered the same training and induction as substantive staff and their training was continuously monitored as for permanent staff.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience. However, managers regularly reviewed and adjusted staffing levels and skill mix, and offered locum staff a full induction.

Medical care (including older people's care)

The service did not always have enough medical staff to keep patients safe. Clinical leaders confirmed that there were not enough medical staff. They explained that this was particularly the case for medical outliers, as when escalation areas were opened to accommodate increased numbers of patients, these areas were not staffed by existing medical staff arrangements. The service currently experienced medical outlier numbers in the region of 30-40 per day. Due to difficulties obtaining locum doctors, this resulted in escalation areas being covered by existing medical staff, of whom there were not adequate numbers to do so.

The medical staff matched the planned number. The full time equivalent (FTE) actual was close to or exceeded FTE budgeted. However, leaders we spoke with and our inspection findings suggested the FTE budgeted was inadequate to meet requirements.

The service had variable vacancy rates for medical staff. For July 2022, data showed a 7.8% vacancy rate (3.25 FTE) for FTE consultants in medicine.

The service had high turnover rates for medical staff. Turnover rates were high for the period February to July 2022 varying between 20.1 and 22.4% with no trend.

Sickness rates for medical staff were variable. Sickness rates varied between 3.2 and 5.8% from February to July 2022 with no trend.

The service had variable rates of bank and locum staff. From February to July 2022 use of bank staff was stable with no trend, varying between 1 and 2.6%, with July having the lowest rate at 1%. Over the same period agency use varied between 2.8% and 6.8% with no trend.

Managers could not always access locums when they needed additional medical staff. Clinical leadership reported that it was very difficult to obtain locum staff to meet the fluctuating demands of the medical service. When locum staff could not be accessed, leaders moved existing medical staff to provide cover where possible.

Managers made sure locums had a full induction to the service before they started work. Staff we spoke with told us locum staff were required to complete an induction before starting work and this applied even at short notice, where there was a system in place for locums starting their shift to take time before the shift to complete the necessary induction items.

The service always had a consultant on call during evenings and weekends. There was always a consultant on call out of hours. The respiratory service had a separate on-call consultant in addition.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, they were not always stored securely.

Patient notes were comprehensive and all staff could access them easily. Patient notes were paper and stored in trolleys on the wards so were readily available. Paper records for current admissions were then scanned after discharge and became digital. This meant staff could view past admission details electronically.

Records were not always stored securely. The trolleys in which notes were stored were lockable, however there were times when we found these trolleys unlocked. This was typically when there were a lot of notes in use at the time, for example during ward rounds, which would make it practically more difficult if the trolleys were locked each time.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes for safely prescribing, administering, recording and storing medicines. An electronic prescribing and medicines administration (EPMA) system was in place. We looked at a sample of electronic prescription records and saw that weights were recorded to allow for safe prescribing of weight-based medicines. However, allergies were not always recorded on EPMA which meant that there was a risk of harm if a patient received a medicine they were allergic to.

Patients on high-risk medicines were monitored appropriately. For example, patients prescribed insulin had their blood glucose levels regularly checked and sent automatically to the specialist diabetic nurses, so abnormal readings could be actioned promptly.

Medicines and controlled drugs (medicines requiring additional controls due to their potential for misuse) were stored securely. However, fridge temperatures where medicines were stored were not consistently recorded and so we could not be assured that medicines were always safe and effective to use.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Medicines were reviewed regularly on ward rounds. Clinical pharmacists regularly visited the wards, reviewed medicines and would speak to patients about their medicines when required. Ward staff knew how to contact a pharmacist for advice when necessary. Patients were provided with specific advice on discharge where appropriate. Staff regularly referred patients to community pharmacies via the discharge medicines service to ensure that changes to medicines could be followed up.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Electronic devices used when prescribing and administering medicines were secured when not used by staff.

Staff followed current national practice/guidance to check patients had the correct medicines.

Pharmacy staff prioritised new patients to review their medicines. Medicines reconciliation (the process of accurately listing a patient's medicines they were taking at home and comparing it to what is prescribed whilst they are in hospital) was mostly completed in a timely manner. Staff had access to summary care records to support this process.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff received information about safety alerts and learning from medicines incidents through regular newsletters. We saw that themes from medicines incidents were identified and action plans put in place to prevent these incidents from recurring.

Incidents

Medical care (including older people's care)

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with were able to explain what incidents to report and how to report them using an electronic system. Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw that serious incident investigation reports had been shared with relatives and that corresponding letters of apology had been sent. The service had no never events on any medical wards.

Staff received feedback from investigation of incidents. We saw ward newsletters which were produced for staff on a regular basis and which contained details of incidents that had occurred and the learning and actions to be taken from these. Staff we spoke with reported that incidents and actions resulting from these would be discussed at daily ward handovers and meetings.

Staff met to discuss the feedback and look at improvements to patient care. Patient experience results were recorded using an online tool. The results were shared monthly and reviewed by the relevant Matron, Deputy Head of Nursing and Head of Nursing.

We saw the minutes of clinical governance meetings where incidents were discussed, learning from these was shared and action plans created. There were also 'learning from deaths' meetings so that information was shared and improvements could be made.

There was evidence that the service responded to patient safety alerts. We saw an example where a patient safety alert relating to the safety of non-invasive ventilation machines required actions to be put in place to reduce the risk associated with a fault on these machines. We saw that the service had created a risk assessment process for this and had a process for adjusting staffing levels accordingly.

Is the service effective?

Good 

We have not inspected this service before. We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff generally followed up-to-date policies to plan and deliver care according to best practice and national guidance. The policies we saw were dated, version controlled and had future review dates. However, the endoscopy standard operating procedures (SOPs) we received were new and did not have dates or review dates showing.

Generally clinical practice reflected guidance and best practice. Key issues in patient care were handed over and discussed with a multidisciplinary team where relevant. Senior clinical staff gave support to junior staff to help ensure patients received care and treatment based on national guidance.

The service did not have a dedicated high dependency unit (HDU). However, these patients could be managed on AAU, Pilgrim ward and CCU depending on their clinical needs and would be accepted on intensive care if most appropriate. There was daily support from the critical care outreach team, which was a consultant-led team, and which would see level 2 patients multiple times per day regardless of their location, as needed.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. Handover information included details of psychological information where relevant. We observed a multidisciplinary team meeting where these aspects were discussed if relevant. The In-Patient Admission Bundle included a psychological and spiritual wellbeing assessment and care plan.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered three meals a day. Staff supported patients to eat and drink if needed and provided fresh water. However, we heard from a patient that the food was cold when it arrived and from another that it was unpalatable.

Staff mostly fully completed patients' fluid and nutrition charts where needed but this was not always accurate. The nursing quality dashboard for April to July 2022 showed that in most cases wards were 100% compliant with maintaining patient food and drink records. However, a large proportion of wards were well below the compliance target for accurate completion of fluid charts. This meant that decisions on fluids might be made based on incorrect information.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The service used the Malnutrition Universal Screening Tool (MUST). The nursing quality dashboard for April to July 2022 showed that the majority of wards were 100% compliant with completing the MUST score accurately within 24 hours of admission and reassessing this at least weekly.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Medical and nursing staff could make referrals for support from dietitians and Speech and Language Therapists for patients. Patients received individualised nutrition and hydration care plans.

Pain relief

Staff generally assessed and monitored patients to see if they were in pain, and gave pain relief in a timely way based on findings during our visit. Staff supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The service used a pain score and the pain ladder to guide pain relief medicines. Pain was assessed on admission as part of the admission bundle nursing assessment and evaluation, which also included a pain care plan of core care actions

applying to all patients and individualised care actions specific to individual patients. This admission bundle also included prompts to consider patients being admitted with pre-existing chronic pain (preadmission pain status and medicines) already on painkillers and a prompt to ensure a device care plan was in place for patients on patient-controlled analgesia (PCAs) or epidurals.

Staff were aware of the Abbey pain scale for use with patients who were not able to communicate their pain conventionally. The Abbey pain scale is a tool used to measure pain in patients who cannot verbalise their pain clearly. It involves making an assessment of other aspects including changes in facial expressions, behaviour, body language, and physiological and physical changes.

The service had a specialist pain team that could be contacted for advice on pain management. Staff we spoke with were aware of the pain team and how to make referrals to them for individualised advice and said they would contact them for difficulties with pain management.

We requested pain management audits however these had not been completed in 2020/21 due to COVID-19, sickness and redeployment. They were planning to complete the pain audit for the medicine service towards the end of 2022.

Patients generally received pain relief soon after requesting it. The May 2022 ward accreditation data we saw showed that for all wards except one, hospital staff did everything they could to help control the patient's pain by assessing the patients pain score accurately and therefore act and treat appropriately. However, we heard from a patient that they had needed to prompt staff for pain relief and there were delays in them receiving pain relief. As pain management audits had not been completed, we did not know whether patients received timely pain relief more broadly speaking.

Patient outcomes

There was evidence that staff monitored the effectiveness of care and treatment. They generally used the findings to inform improvements to be made.

The service participated in relevant national clinical audits. We saw evidence of participation in national audits for lung cancer, heart failure, asthma/COPD, dementia and stroke.

Outcomes for patients were not always positive, consistent or met expectations, such as national standards. The National Early Inflammatory Arthritis Audit Second Annual Report, for data collected May 2019/2020, (no participation in 2021/22 due to insufficient clinical time) showed that the service consistently met expected national standards and performed above the national average for some recommendations.

We saw documentation stating that the trust already met most of the recommendations arising from the national asthma and COPD audit published in June 2022.

A national audit of inpatient falls dated August 2022 showed partial compliance and acceptable performance to the comparator set. At the time of our inspection, we did not know whether an action plan was in place (as the data had only been recently published). However, the trust had a falls strategy in place.

A local audit of statin use in secondary stroke prevention for data collected August to December 2021, proforma dated May 2022, showed partial compliance and an action plan was in place. We do not know whether the actions have led to improvements or not yet as the re-audit is planned for January 2023.

Endoscopy managers monitored the effectiveness of care and treatment and used findings to improve them. The service had achieved Joint Advisory Group (JAG) accreditation, endoscopy outcomes / key performance indictors and individual endoscopist's outcomes were audited on a quarterly basis using the Global Rating Scale (GRS) as identified by JAG.

However, there were some audit results we saw where the interventions made did not always result in improvements. For example, we saw an audit outcome report dated February 2022 for management of diabetic ketoacidosis showing auditing over three cycles. Results showed that for half the parameters there had been no improvement, and these remained poorly compliant. (data collection period January 2020 to November 2022).

We saw an audit of thoracentesis standards against national guidelines for data collected from September 2021 to February 2022, which showed a 55% adherence rate with the guidelines, for cycle 2 of the audit following interventions.

We could not be sure that managers and staff always used the results to improve patients' outcomes. We saw that audit results were discussed at governance meetings and some action plans were created. However, we did not see robust evidence to confirm that actions had been implemented and outcomes had improved as a result of these actions. For example in the national heart failure audit latest report the recommendations were only partially met, action plans were in their infancy, however results had only been released very recently in June 2022.

The National Audit of Dementia report for the pilot audit was received in June 2022 and we saw actions identified as a result of this but no measures of timeframe or progress at this stage.

We requested the local clinical audit programme for medicine with completion data but did not receive this. We saw that some individual audits had been completed but there was no definitive audit plan and status update.

We did not have enough information to say whether managers used information from the audits to improve care and treatment. We saw that audit data was discussed at a variety of meetings at different levels and actions identified, however we did not see robust evidence of audit data being used to improve care and treatment based on the information given.

Managers shared and made sure staff understood information from the audits. Staff we spoke with told us that they were informed of audit results via the ward newsletters and at handover and team meetings.

We saw the minutes of the service meetings for March, June and July which showed that both national and local quality improvement projects were presented and there was opportunity to escalate any issues.

Competent staff

The service generally made sure staff were competent for their roles. Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were generally experienced, qualified and had the right skills and knowledge to meet the needs of patients. All medical staff were currently up-to-date with their revalidation. The monthly registrations and revalidations report for all Nursing and Midwifery Council (NMC) registrants for 1 August 2022 showed that 100% had current NMC registration. Any registrants that had not met the relevant requirements would be placed in a non-clinical and non-patient facing role until their registration was regained.

However, due to staff shortages, staff would sometimes be moved between different wards, meaning they may be working in an unfamiliar environment on these occasions.

The trust was unable to demonstrate that all new staff had a full induction tailored to their role before they started work. We asked the trust for induction compliance and completion rates for new starters but did not receive this. However, staff we spoke with during our visit told us they had received an induction. The trust explained that the induction had moved online due to the COVID-19 pandemic, and all permanent and temporary staff had 8 weeks from their start date to complete the core statutory and mandatory training. Where required, staff would attend face-to-face sessions, for example clinical support workers were expected to attend a 5-day face-to-face induction. The trust was developing a new cross-site induction policy which it was aiming to finalise for September 2022.

Managers generally supported staff to develop through yearly, constructive appraisals of their work. The current medical appraisal rate supplied was 91.2% against a target of 90%. However the nursing appraisal rates showed an average compliance across medical wards of 81%, and within this there were a significant number of wards showing significantly lower compliance rates.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with at the inspection told us that they were able to discuss training needs at appraisals and had the opportunity to pursue additional training. However on the question of 'able to access the right learning and development opportunities when I need to' in the 2021 NHS staff survey, there was a mixed picture, with some medical wards comparing favourably against the comparator of the organisation as a whole, and some poorly. However, this was during the time of the COVID-19 pandemic.

There were examples of staff receiving specialist training for their role. These included the respiratory and cardiology wards where staff received training in non-invasive ventilation (NIV). The respiratory ward had recently run a respiratory training day covering relevant items for the respiratory nursing role, and also provided on the job NIV training and critical care level one training to manage level 2 (high dependency) patients, who were often managed on the respiratory ward.

Junior medical staff had an allocated clinical supervisor. Nursing staff attended daily safety huddles where all patients on that ward were discussed. There were handovers at shift changes, during which patients, operational matters and any incidents and complaints would be discussed.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. On the wards we visited there were daily multidisciplinary team (MDT) meetings which were attended by different members of the MDT which included doctors, physiotherapists, ward sister or manager and discharge planner. Items such as discharge dates, social backgrounds, occupational and physiotherapy, actions required, discharge paperwork, Do Not Attempt Cardio-Pulmonary Resuscitation orders (DNACPRs), investigation results, symptom management, medications and specialty reviews needed were discussed.

Medical care (including older people's care)

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff could make referrals to other clinical specialties, including mental health, for advice and support. Physiotherapists, occupational therapists, dietitians and speech and language therapists, specialist nurses and social workers were involved in patient care as required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff could make referrals to the psychiatric liaison service as required.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants did not lead daily ward rounds on all wards. Leaders told us there was on-call support from a consultant at weekends, but no weekend ward rounds.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was an on-call medical team available out of hours. The psychiatric liaison team was accessible for mental health support out of hours. Diagnostic tests required for urgent management decisions were available out of hours. The service always had senior nurses on site and staff had access to an on-call general manager and senior nurse at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw posters and information leaflets in the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The In-Patient Admission Bundle Nursing Assessment and Evaluation paperwork included a 'Making Every Contact Count' section which assessed aspects such as alcohol, smoking, eating well, physical activity and mental wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. Some staff knew how to support patients who lacked capacity or were experiencing mental ill health to make their own decisions. Senior staff knew the process for limiting patients' liberty. Staff knew the elements of valid consent, but consent had not been audited to ensure that staff always followed national guidance to gain patients' consent.

Staff understood when to assess whether a patient had the capacity to make decisions about their care but did not always understand how to assess this. Staff we spoke with were able to explain when patients may require a capacity assessment to make decisions. Depending on their role, some staff had not been trained in assessing capacity. Staff said they would refer this to more senior colleagues to carry out a capacity assessment.

The service used a formal mental capacity assessment document which meant relevant staff were guided through the requirements of capacity assessment and this assessment proforma was documented and stored in the patient record.

Medical care (including older people's care)

We could not be sure that staff always gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with were able to explain the elements of valid consent and the patients we spoke with at inspection reported that staff asked for consent, explained things and gave time for questions. However, we requested a consent audit for medicine but did not receive this. Therefore we could not be sure that consent was always gained in line with legislation and guidance.

Specific training for registered nurses within the endoscopy department was provided on consent as part of staff induction competencies. We reviewed three sets of patient records and saw all consent forms had been fully signed and completed.

When patients could not give consent, staff made decisions in their best interest. The formal mental capacity assessment document also included a section on best interest decisions for those patients assessed as not having capacity to give consent for that decision. We saw some DNACPR forms where patients had been assessed as not having capacity, and there was a corresponding Mental Capacity Act (MCA) and best interests form assessment for these.

Staff did not always receive and keep up to date with training in the Mental Capacity Act (MCA). MCA and consent training was included in Safeguarding Adults Training at all levels. Training in these topics was therefore not recorded separately. The trust produced compliance figures of 76% for medical staff and 85% for nursing staff. The trust had organised 25 MCA and consent sessions starting in September 2022 to be delivered by a legal firm to ensure a further understanding of these subjects for key members of staff.

The trust had made arrangements for mental health training to be delivered. They reported that Mental Health First Aid Training was currently being provided, which was not mandated but was available to staff to access if their role allowed the training. In addition, Mental Health First Aid UK was going to provide the trust with Mental Health Awareness sessions, which had not yet been set.

Staff implemented Deprivation of Liberty Safeguards (DOLS) in line with approved documentation. The more senior nursing staff we spoke with were able to show us completed documentation for DOLS and describe the process of making and extending DOLS applications.

Managers had not recently monitored the use of DOLS to make sure staff knew how to complete them. There had been no audits on DOLS in the last 3 months. This had been discussed at a recent team meeting and identified as an action on the action log.

Managers had not recently monitored how well the service followed the Mental Capacity Act, so would not be aware of performance in this area or whether any changes to practice were necessary. The team was currently completing an MCA audit, which was a focus currently to ensure staff were competent on the MCA leading up to the impending implementation of Liberty Protection Safeguards (LPS). The LPS is due to replace the DOLS system and are intended to provide protection for persons aged 16 years and over who do not have the mental capacity to consent and who are, or who need to be, deprived of their liberty to enable their treatment.

Is the service caring?

Good 

We have not inspected this service before. We rated it as good.

Medical care (including older people's care)

Compassionate care

Staff generally treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were generally discreet and responsive when caring for patients, and generally interacted with patients and those close to them in a respectful and considerate way. Of the patients we spoke with during the inspection, most felt staff were discreet, responsive, respectful and considerate. However, we heard from one patient that prompting of staff had been required for pain relief and no explanation of how to work the bed and call bell had been given upon arrival on the ward. A few responses from patients we spoke with reported that sometimes when discussing their care with them, staff spoke at volumes which may be audible to other patients in the same bay.

One of the safety huddles we observed took place in the main patient bed area which meant that it was possible that patient information was audible to other patients on the ward.

Patients said staff treated them well and with kindness. Patients we spoke with at the inspection agreed that staff treated them with kindness, although one response described that interactions could be ‘matter of fact’.

Staff generally followed policy to keep patient care and treatment confidential. Patients we spoke with at the inspection agreed that their privacy and dignity was largely maintained, except for discussions sometimes being at volumes which could be overheard, therefore not always being confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients we spoke with at inspection agreed that these various needs were met. We saw that handover sheets included information on these aspects. We also heard that ear plugs and eye masks had been made available in response to noise on wards at night.

Emotional support

Staff generally provided emotional support to patients, families and carers. They generally understood patients' personal, cultural and religious needs.

Staff generally gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with at inspection agreed that staff provided emotional support to them and their relatives when needed.

Staff generally understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Patients we spoke with at inspection agreed that staff understood this.

Understanding and involvement of patients and those close to them

Staff generally supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand. Patients we spoke with at inspection reported that staff spoke to them in a way they could understand and would rephrase information differently or simplify it if required.

Medical care (including older people's care)

Patients and their families could give feedback on the service and their treatment. Patients were given electronic tablets for feedback when they were ready to be discharged, or sent a paper feedback form by post, to collect their views on their care. Patients we spoke with at inspection said they knew how to complain or raise a concern if they wanted to and felt they could approach staff, except for one patient who did not know how to complain and did not feel able to feedback to staff.

Staff supported patients to make informed decisions about their care. Patients we spoke with at inspection reported that staff explained their care to them.

Patients generally gave positive feedback about the service. The feedback given by the patients we spoke with during our visit was generally positive. The patient feedback supplied by the trust for the months January 2022 to July 2022 was positive in the vast majority of cases, with most responses feeding back that the ward was either 'very good' or 'good'. However, we did not receive details of the questions posed to patients, therefore we do not know what aspects of care these responses related to. The average response rate for the patient feedback survey was low, being approximately 20% for most months, with a few months having a response rate less than this. The trust explained that staff had been encouraged to focus on direct patient care at times of extreme operational pressures over recent weeks, and therefore some departments had a low response rate.

Is the service responsive?

Good 

We have not inspected this service before. We rated responsive as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional support or specialist intervention. There was access to dietitians, speech and language therapists (SALT), physiotherapists, and other clinical specialties for opinions.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The psychiatric liaison service was available 24 hours a day and 7 days a week.

There was a learning disabilities team which worked 8am to 4pm Monday to Friday, however 3 out of the 4 WTE in the team were currently vacant. Additional support was being provided by one of the community learning disabilities nurses. New admissions out of hours would be seen by the learning disabilities team the next working day.

Managers monitored and took action to minimise missed appointments. We asked the trust for details of the systems used for monitoring and minimising missed appointments. The online patient access policy stated that outpatient appointments must be given at least three weeks' notice except for urgent appointments which were given a minimum of 48 hours' notice. The policy stated that the best way to reduce the number of missed appointments (DNAs) was by agreeing the date with the patient in advance and in a manor appropriate with their known language or disability needs.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The Psychiatric Liaison Service provided advice on mental health conditions. There was a learning disabilities team available during normal working hours. There was an Admiral Nurse service available to all staff, patients and visitors for dementia care from Monday to Friday 8am to 4pm and the 24 hour a day Psychiatric Liaison Service would support staff and patients with an acute presentation or changes in condition relating to dementia. The Safeguarding Adults team were able cover any urgent issues or advice in the absence of the Admiral Nurse.

Wards were designed to meet the needs of patients living with dementia. The hospital used recognised guidance to ensure the hospital environment and wards were dementia friendly. The local ward accreditation process also drew upon this with areas directly linked to the guidance.

We saw that patients with dementia or cognitive impairment had a blue or white butterfly displayed over their bed to indicate they had needs associated with dementia or cognitive impairment. Staff we spoke with were aware of how to access specialist mental health or learning disabilities advice and support.

Patients who had a learning disability, dementia or other cognitive impairment were identified at ward handovers and safety huddles.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There were activities coordinators who completed 'all about me', or 'this is me' documentation for patients with a cognitive impairment, dementia or learning disability.

Staff were aware of ways to meet the information and communication needs of patients with a disability or sensory loss. Staff we spoke with were able to describe communication aids for patients not able to communicate in the conventional way.

Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed. There was a telephone-based interpretation service which allowed immediate access to an interpreter 24 hours a day. Face-to-face interpreters required booking in advance. Signing could be arranged through the Patient Advice and Liaison Service (PALS). Low vision support services were available, which included printing documents in larger font sizes, and guidance on bringing assistance dogs into clinical areas.

Access and flow

Medical care (including older people's care)

People could not always access the service when they needed it to receive the right care promptly. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were generally better than the England average.

Managers worked hard to ensure that patients could access services when needed and received treatment within agreed timeframes and national targets. Data we reviewed demonstrated that the trust was performing well for referral to treatment times for admitted and non-admitted patients. There was an acknowledgement that access and flow was significantly impacted by external factors and the service worked with internal and external stakeholders to make improvements.

Managers generally made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The service had high numbers of medical patients on non-medical wards or escalation areas, typically in the region of 30-40 patients each day. There was a medical outlier team provided by the acute medicine team for reviewing these patients which included a consultant and junior doctors. The outlying team consultants would rotate on a weekly basis. However due to difficulties obtaining locum staff to cover escalation areas, junior doctors for the outlying team would be made up of those from existing medical areas. Therefore we were not assured that the service was always able to deploy the required number of medical staff to meet the needs of medical patients within the service.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw that discharge dates and discharge related processes were discussed daily at ward MDTs. There were also length of stay meetings. The trust was in the process of developing the frailty service at Bedford, for which one of the aims was to minimise unnecessary time in hospital and help discharge patients as early as possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There was a discharge planning team who attended ward MDTs and were able to coordinate the different services required for patients with complex needs. The service worked to the Department of Health and Social Care Hospital Discharge and Community Support Guidance.

Managers monitored the number of patients whose discharge was delayed. Discharge situation reports were reviewed on a daily basis. We saw the daily discharge situation reports covering 25 July to 14 August 2022. For the week commencing 25 July, on the majority of days the service discharged approximately half of those patients who did not meet the criteria to reside in hospital. For the 2 weeks in August, on the majority of days the service discharged less than half of those patients who did not meet the criteria to reside in hospital.

The service reviewed patients with increased length of stays and looked for opportunities to improve the patient flow. Patient length of stays were reviewed at weekly length of stay meetings with a multidisciplinary team. Managers worked to minimise the number of medical patients on non-medical wards. At hospital site meetings throughout the day this information was reviewed and mitigated where possible. However the number of medical outliers was frequently significant.

People could generally access the endoscopy service when they needed it. The service had worked hard to reduce waiting times and had made significant improvements in performance since August 2021. As of July 2022, the service was now performing better than the England average. However, the endoscopy department was used as an escalation area during extreme bed pressures. During escalation protocols, endoscopy patients were recovered within the theatre recovery area which was positioned down the corridor from the endoscopy department. This area did not have any patient toilet facilities. Staff told us that the lack of toilet facilities caused patients concern when recovering from lower bowel scope procedures.

Medical care (including older people's care)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. The service displayed information and contact details for leaders on the ward so that patients and relatives knew who to contact if they had any concerns. In the last 12 months there had been 66 complaints for the medicine service.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with during the inspection were able to explain how they would approach patients and relatives who wished to make a complaint.

Managers investigated complaints and identified themes. We saw that complaints had been looked into and themes identified in the minutes of meetings and in ward newsletters. For example, clinical service line meeting presentations discussed information on complaints for that month, with themes and learning identified. Service line executive review meeting minutes also showed evidence of discussion of complaints and themes.

The results of patient experience surveys were shared monthly and reviewed by the relevant Matron, Deputy Head of Nursing and Head of Nursing. Wards and services were also required to attend Quality Performance Management meetings on a rotational basis throughout the year where this information was looked at by the Chief Nurse, Director of Nursing, Deputy Directors of Nursing, and where trends and actions were discussed.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Is the service well-led?

Requires Improvement 

We have not inspected this service before. We rated well-led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced, but were not always able to manage them well. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medicine service was arranged into clinical service lines. Each service line had a General Manager, a Clinical Lead and Head of Nursing. Clinical service lines were directly accountable to the Executive Board and had their own service line and governance meetings.

Medical care (including older people's care)

Leaders understood the challenges to quality and sustainability. The challenges they identified included hospital patient flow, increased numbers of medical outliers within the service and staffing. Although leaders had identified the actions needed to address them, they were still in the process of unifying the medical care services post-merger. This meant we found that actions that were being implemented to address challenges across both locations were at different stages of progression. For example, the development of the frailty service and management of audits.

Medical wards had a ward manager and/or ward sister who were supported by matrons. The ward managers and ward sisters we spoke with on the wards we visited were visible and engaging and had good knowledge of operational matters and the patients on their wards.

As part of the inspection we interviewed ward managers and matrons, head of nursing and clinical leads and general managers. All were engaging and demonstrated good understanding and knowledge of operational matters.

Staff we spoke with found leaders approachable and accessible for anything they may want to discuss. Leaders proactively sought to make themselves visible and accessible to both staff and patients. Ward manager details were displayed on wards to enable easy contact by patients and relatives, and some ward managers said they would approach new patients to introduce themselves and explain their role.

Some clinical specialties had arranged dedicated points of contact via email or telephone for patients and GPs requiring advice, or nurse support lines for patients with chronic conditions to obtain specialist advice more easily. There were weekly drop-in sessions for staff in some specialties, to act as an open door for staff to bring discussions at any time regardless of their seniority or role.

Looking to the future, leaders appreciated the need for succession planning and maintenance of the workforce in the face of approaching retirement of colleagues.

The COVID-19 pandemic had resulted in significant backlogs and the trust had been working with the Integrated Care System (ICS) on ways to safely remedy these. Together with this, increased demand had been noticed, possibly due to difficulty with access to primary care.

Leaders appreciated the need to be proactive in anticipating problems in the future. The winter planning meeting was due in September to plan ahead for winter pressures.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The vision of the service was ‘to continue delivery of safe, sustainable and high-quality services for the people of Bedfordshire and to develop the services so that they are all either “Good” or “Outstanding” and ‘to take a more proactive role outside the hospital walls, preventing as well as treating ill health, integrating with our partners in the Bedfordshire Health and Social Care System and acting as an anchor institution in our community’.

The trust’s ethos was ‘every patient matters’. The mission statement for the service was ‘To employ the best people and develop and value them, so that the teams they work in provide outstanding care to the local population’.

Medical care (including older people's care)

The trust had recently undergone a merger of the two hospital sites, the Luton and Dunstable and Bedford Hospitals sites, in 2020. Development of the clinical strategy had been intentionally reserved for after the merger had taken place, 'in order to allow the cross-site clinical relationships to develop and provide the right long-term foundation for discussions regarding integration'. Following the merger, different clinical service lines worked to identify their priorities for clinical integration and produced strategies which were at different stages of development, but the aim was for these to ultimately come together to produce an overarching clinically led strategy. Several of the individual service line strategies had been approved through the Clinical Validation Committee and then the Clinical Strategy Board. These emergent strategies were used to inform phase one of the Clinical Strategy Framework, which had now been completed.

The clinical strategy framework acknowledged the importance of the trust values to successfully achieving the strategy. The trust 'THRIVE' values were:

Teamwork

Honesty

Respect

Inclusivity

Valuing People

Excellence.

Culture

There was a mixed picture with respect to whether staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

The clinical strategy framework recognised and acknowledged the importance of staff to the successful achievement of the clinical strategy. It talked about championing staff health and wellbeing as a key factor and about staff being at the centre of the strategy, and their empowerment to develop sustainable plans for patients and the local population that provided high quality care.

Staff we spoke with during the inspection were positive about the culture, saying that it was friendly, with lots of support, and that people all helped each other. They felt the service was open and honest. Clinical leads said they all supported each other, even when not on call, and that there was good will amongst the consultant body.

The 2021 NHS Staff survey showed that for items such as 'colleagues are understanding and kind to one another' and are 'polite and treat each other with respect', results compared favourably with the organisation results overall on a good amount of medical wards, but there were also several wards which compared poorly, giving a mixed picture overall on these parameters for medical wards. On the questions of 'receive the respect I deserve from my colleagues at work', and 'feel valued by my team' there was also a mixed picture, with some medical wards comparing favourably, and others unfavourably, against the comparator of the organisation overall.

Medical care (including older people's care)

Leaders presented a mixed picture of staff morale. The pandemic had taken a heavy toll on staff morale and work remained very challenging on a daily basis. It was suggested that staff were in less of a position than before to go the extra mile as a result of this. However, leaders felt the trust was listening to staff and trying to support them. There was a sense that things were starting to get back to normal after the pandemic. They recognised the importance of supporting junior staff and the trust had provided ways to enable leaders to support their staff, such as the medical leaders' forum run by directors of integration, which was a drop-in session for clinical leads to access for advice on how to support staff.

Governance

Leaders mostly operated effective governance processes, throughout the service. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

In the merged governance structure, the core units of leadership and decision making were 'Clinical Service Lines', which were directly accountable to the Executive Board. Matters of risks, quality, performance, strategy and the identification of areas requiring more executive support or oversight were addressed by Executive review meetings. There were then cross-cutting boards chaired by senior clinicians which facilitated strategy and collaboration on issues occurring across service lines.

The different clinical service lines within the medicine service held their own service line and clinical governance meetings. We reviewed clinical governance meeting minutes for most of the clinical service lines. We saw that matters including incidents, audits, complaints, compliments, patient experience, risks, risk register and risk management and action logs were discussed at these meetings. The way these items were presented and discussed varied between service lines and the agendas did not appear to be standardised.

Clinical service lines would report their clinical governance matters upwards to the Clinical Quality Operational Board (CQOB). This report sought to provide assurances to the CQOB on matters of quality, safety and performance, including improvement actions, timelines and leads for delivery for quality, safety and performance indicators requiring improvement. We saw evidence of meetings where clinical quality governance reports were presented and discussed. The format of these varied between service line groups.

The meetings were attended by staff of appropriate seniority for the matters under discussion. Meeting minutes generally contained adequate detail to understand the discussions and decisions arising from the meetings. Actions generally showed ownership/accountability and a sense of timeframe.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

During our inspection we found, there was not a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. This was demonstrated through the lack of audits such as Mental Capacity Act and action plans to address other areas of concern we identified in the 'Safe' and 'Effective' sections of the report. We saw evidence of participation in national and local audits, although we could not always be sure that actions had been implemented and had resulted in improvements being made where necessary. This is another area where we saw that leaders were still working to ensure that processes were aligned across both sites.

Medical care (including older people's care)

Leaders we spoke with had confidence that the systems for incident and safety matters were robust. We saw that incidents, complaints and audit results were discussed at clinical service governance meetings and mortality reviews, with some actions identified for improvements.

The service maintained a risk register which gave details of risks, the control measures in place, ownership, review date and risk rating level for the different clinical service lines. Ownership of risks and their control measures was allocated to specific individuals, and there was an area on the register where they could provide date and time-stamped risk reviews to monitor progress.

Risks could be escalated by Clinical Service Lines to the Executive Board, which could provide Executive support and oversight of risks as deemed necessary.

Risks, incidents, complaints, audits and performance data were reported upwards into CQOB reports and discussed at individual service line Executive Performance Review meetings.

The clinical and non-clinical leaders we spoke with as part of the inspection demonstrated a good awareness and understanding of the risks existing in their areas and for the service as a whole.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions. The information systems were secure.

The trust had a digital strategy which involved merging the clinical systems between the two sites and moving towards increasingly electronic records, which was at the planning stage.

We saw that the service collected data on quality and performance metrics and that this was used to inform a view of the service and to prompt improvement initiatives.

Information governance and data security training was part of the mandatory training programme, however the compliance target of 95% had not been met for either nursing or medical staff. There was an action plan in place to improve mandatory training compliance in general.

Wards had computer terminals to allow staff to access patient results and trust guidelines and policies through the trust intranet. However, it could be time consuming to locate policies on the intranet if the specific guideline name was not known, due to the way the search function worked. Staff had individual logins and passwords to access this information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward leaders explained that they would introduce themselves to new admissions and relatives on the ward, so they knew who to come to if there were any problems. Details of ward leaders were displayed in the main areas of wards to inform patients and their relatives of who to contact with any queries or concerns. When patients were ready to be discharged staff collected feedback from them about their experience using an electronic tablet or posted paper feedback forms to those not able to use the electronic tablet.

Medical care (including older people's care)

Staff we spoke with told us they felt involved and engaged and listened to by leaders and felt they could approach them with suggestions for improvements or concerns. The trust participated in the 2021 NHS staff survey to gain staff views on multiple aspects of their work. We saw that for the parameter 'Able to make suggestions to improve the work of my team/dept' some of the medical wards compared favourably with the comparator organisation results overall, but some compared poorly on this aspect. Similarly, the parameter 'Able to make improvements happen in my area of work' showed mixed results across medical wards, with some comparing favourably and others not. Information about incidents, complaints, compliments and operational aspects was shared with staff at daily ward handover meetings and via ward newsletters. There were also 'safety huddles' where staff reviewed all patients on the ward and were able to raise any problems. Staff we spoke with were less sure about the overall strategy of the organisation but this was felt to be due to this being in a developmental phase.

The trust was part of the Bedfordshire Care Alliance (BCA). The vision of the BCA was 'To deliver improved outcomes for residents across Bedfordshire and reduce the health inequalities in the diverse communities within Bedford Borough, Central Bedfordshire and Luton. This will be achieved through providing integrated health and care services that are easy to access and tailored to the needs of our local residents.' To achieve the BCA aims in improving services, NHS services would work with local authorities to take shared responsibility for planning and delivering health care integrated with social care. By doing this it was hoped that this would lead to better outcomes for local people, better use of resources and reduce inequalities.

We saw that there was a Care of the Elderly Bedfordshire Clinical Interface Forum that was collaborating in the development of a primary secondary care interface in the Bedfordshire Care Alliance. The purpose of this forum was to facilitate collaboration between primary and secondary care clinicians to provide an interface and environment that facilitated the achievement of objectives of the Bedfordshire Care Alliance, and to provide review and feedback on services and pathways to help provide safe and high quality services across the county. We saw an open action log for the clinical interface forum.

The trust was a partner in the Integrated Care System (ICS) which worked to improve population health outcomes across Bedfordshire. Part of the trust's vision was to be more proactive externally in the prevention of disease, as well as the treatment of disease and in integrating with other partners in the Bedfordshire Health and Social Care System (with the aim of acting as an 'anchor' institution in their community).

As a partner in the ICS, the trust would be involved in ICS projects such as the development and expansion of virtual ward capacity, a national programme to create a 'safe and efficient alternative to NHS bedded care that is enabled by technology'.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Wards and services attended Quality Performance Management meetings on a rotational basis throughout the year where this information was further looked at by the Chief Nurse, Director of Nursing, Deputy Directors of Nursing, and where trends and actions were discussed and agreed. The hospital was planning to develop a frailty assessment and short-stay unit and grow this service over time. A two-week pilot of the frailty unit had been completed. This was in response to the identification of frailty as one of two main emergency streams admitted to the medicine service and a need for frailty provision, together with considerations around bed capacity and availability. The objectives of this

project included ensuring specialist and holistic assessment of patients with frailty syndromes as early as possible, to ‘assess to admit’ and identify patients suitable for the earliest possible safe discharge to reduce hospital associated harm such as hospital acquired infections, including same day or next day discharges, and prevent social admissions. Those for whom same or next-day discharge was not appropriate would be transferred to the Care of the Elderly service.

The service provided a list of open clinical trials the medicine service was participating in. This showed thirteen trials in the departments of cardiology, neurology/imaging, dermatology, respiratory and infection.

Maternity

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, however not everyone had completed it.

Nursing and midwifery staff received but did not always keep up to date with their mandatory training. Mandatory training data provided by the trust showed an overall completion rate of 76% for core statutory and mandatory training compliance in July 2022 and a 69% completion rate for advanced statutory mandatory training in July 2022 against the trust's target of 90%. Mandatory training was a combination of online training modules and face-to-face training sessions. We were told the service had been working with the training team to improve the completion of staff training. However, nursing and midwifery mandatory training completion has remained an issue since our last inspection.

Medical staff received and kept up to date with their mandatory training. Mandatory training data showed an overall completion rate of greater than the trust's target of 90% for both core statutory and mandatory training, and advanced statutory mandatory training in July 2022. This is an improvement since our last inspection.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training comprised of core statutory training for all staff and advanced statutory training for relevant staff.

The service also held monthly Practical Obstetric Multi-Professional Training (PROMPT). This was evidence-based training for obstetric emergencies, which aided improvement in outcomes for mothers and babies. The overall compliance for staff completion of this training for all staff groups was at 91% for total midwife attendance and 95% for obstetricians (trainees) both of which had met the trusts 90% completion rate.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Information showed nursing and midwifery staff had an 77% compliance in tier 1 dementia training, against the trust target. The medical staff had a 100% completion rate at tier 1.

The service had specialist mental health midwifery team available for support and guidance for both the clinical staff and the woman.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training compliance was monitored by managers, staff were prompted to book training to remain compliant with the trust target. Managers we spoke with confirmed delays in training completion were due to the challenges in releasing staff and they were working with the training team to find solutions.

Data reviewed after the inspection demonstrated the training and learning team had created a mandatory training action plan which included a trajectory to increase compliance over the next 18 months.

Staff told us they had booked bank shifts in addition to their regular shifts in order to attend training days.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff generally had training on how to recognise and report abuse and they knew how to apply it.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Training data showed staff completed safeguarding training for adults and for children levels 1, 2 and 3. Nursing and midwifery staff had a 95% completion rate for safeguarding children at level 2 and an 85% completion rate at level 3, against a trust target of 90%. However, compliance rates for adult safeguarding were 80% completion rate for adult safeguarding at level 2 and a 41% completion rate at level 3. This was not in line with the trust target of 90% and had fallen since our last inspection.

Medical staff received training specific for their role on how to recognise and report abuse. Training data showed an overall completion rate of greater than the trust's target of 90% for both children and adult safeguarding training at level 2. Figures for level 3 training were below the trust target at 80% and 82% for both children and adults safeguarding in July 2022. However, all figures in relation to medical staff receiving safeguarding training had improved since our last inspection.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with understood how to identify any concerns about harassment and discrimination and named the safeguarding midwife, with whom they could discuss any concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff completed training in safeguarding and knew how to apply this in practice. Staff could access support from the safeguarding midwife if they had concerns. The service had staff that specialised in complex pregnancies and a specialist mental health midwife, where needs were identified with known safeguarding and mental health concerns, these specialised team members would advise staff in their care.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding policies in place for both adults and children. The service followed the local authority safeguarding processes to escalate any concerns. The policies and the local protocols were available through the trust intranet system.

Maternity services had additional policies in place for female genital mutilation (FGM), although the policy was outside the review date. Managers told us the policy had been updated, however, there were some required changes before board sign off.

Staff followed the baby abduction policy and undertook baby abduction drills. The policy set out staff roles and responsibilities in the lockdown of the maternity department. The policy was within the review date of September 2023. The service had airlock style doors and patients and visitors were required to be let in or out remotely by staff.

Cleanliness, infection control and hygiene

The service controlled infection risk but staff did not always complete records to show this. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Maternity

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The areas we visited on inspection were visibly clean, with furnishing, such as patient chairs, that were easily cleanable. We saw that cleaning staff stripped, cleaned and remade beds in quick turnaround areas, such as triage and maternity assessment unit, after women were seen and discharged or transferred. However, we saw that staff used the emergency second theatre as a handover room twice a day. Although this room was cleaned, we did not see that it was cleaned immediately following the handover and therefore there was an increased risk of cross infection if it needed to be used for a caesarean section. We fed these concerns back to staff and maternity senior managers, who told us the theatre was rarely used due to the lack of staff available to operate 2 theatres at the same time. However, no risk assessment was available for the potential cross-infection risk.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff in all clinical areas we visited wore PPE appropriately while delivering care to women and disposed of the PPE correctly after use.

We saw staff decontaminated their hands by either washing or using sanitiser before and after patient care. All staff wore uniforms with short sleeves to remain bare below the elbows for effective hand hygiene. All clinical areas had hand washing sinks and hand gel dispensers in staff and patient areas.

Staff consistently monitored hand hygiene practices. We reviewed the hand hygiene audits for maternity inpatient areas for May 2022, which showed these were conducted consistently every month in all clinical areas. All clinical areas scored 100% in the hand hygiene audit and meant the trust had the opportunity to identify issues with hand hygiene and improve practices if needed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff clean clinical equipment and saw they had labelled equipment that was not in regular use with ‘I am clean’ stickers, which were dated.

The service generally performed well for cleanliness. The trust had a comprehensive infection prevention and control audit tool. The audit tool Red, Amber, Green (RAG) rated the scores to demonstrate if an area was compliant. Review of the May 2022 audit of Orchard ward (antenatal and postnatal) and delivery suite showed a significant improvement from audits in August and September 2021. Review of the May 2022 audit showed staff attained more than 90% compliance in all but 3 of the audits completed, with many audits achieving 100%.

The audits gave the service the opportunity to identify areas of non-compliance and to monitor improvements to practice.

Cleaning records were generally up-to-date and demonstrated that all areas were cleaned regularly. However, we saw that records were not completed for all areas in relation to the cleaning of the birthing pool in the delivery suite. Staff told us they would follow guidance to make sure the birthing pool was cleaned properly. Trust guidance we were shown was out of date and referred to the manufacturer’s guidance for details, therefore we were not assured that the birthing pool was cleaned according to the required standards.

Records for cleaning the milk fridge were not available and the milk fridge temperature was 11 degrees when we visited, which was too high to safely store expressed milk. Although staff told us they had reported the temperature fault, they had taken no action to alert mothers not to put expressed milk in the fridge. After we discussed this with staff, they made arrangements for expressed milk to be stored in another fridge and put this advice on the out-of-use fridge.

Environment and equipment

Maternity

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Maternity services at the hospital consisted of a consultant-led delivery suite, a midwife led birthing unit, bereavement suite, antenatal and postnatal ward (Orchard), day assessment unit, triage area and outpatient clinics.

We saw that clinical areas were largely suitable and appropriate for the service that was being provided in them. However, staff within the triage area, consisting of 1 room within the delivery suite, experienced difficulties when more than one woman needed to be seen at the same time. Out-of-hours triage was also dependent on the ability for the coordinating midwife to attend. Night staff going off duty during our visit said they had received an influx of women requiring triage within a short timeframe. This had put a strain on an already busy staff group and meant women were waiting to be seen, although there were no adverse incidents as a result of this.

The trust was aware of this issue as we raised these concerns at our previous inspection. They had put actions in place to reduce the impact of this on staffing, such as having dedicated staff during the day. However, they were unable to increase the number of beds available immediately. They had plans to move elective surgery to the main theatre block, to provide space for emergency surgery in the maternity unit. A business plan had been approved in June 2022 to develop a dedicated triage space on the delivery suite. This would provide 4 triage spaces including 1 private room. Additional waiting space had also been identified. At the time of our inspection, the work to increase space had not yet begun.

Patients from the gynaecology ward had to go through the antenatal and postnatal ward when going to theatre or when accessing meals and drinks. This meant there were patients on the ward as well as the ward's own patients. This had not been identified on the maternity risk register or the abduction policy.

The internal environment of the maternity department had been maintained, however, we saw there were no Entonox scavenging units available in birthing suites. This could result in a build-up of exhaled gases and pose a risk to pregnant women. The trust advised they monitored Entonox levels, although staff confirmed they had not received the results from the facilities team. They therefore could not confirm whether there was a build-up of gases or not.

Women could reach call bells and staff responded quickly when called. Women we spoke with told us that staff responded promptly if they called for assistance. We saw that call bells were answered quickly.

Staff carried out daily safety checks of specialist equipment and kept records that confirmed daily checks were consistently undertaken. Staff ensured that emergency clinical equipment, such as adult resuscitation trollies, oxygen, resuscitaires and suction equipment clean were appropriately stocked and positioned in accessible areas. Resuscitaires are used to support new born babies who may need extra warmth or resuscitation after delivery

The emergency trolleys were secured with tamper-proof tags. We also checked a random sample of consumable equipment stored in the emergency trolleys, which were found to be sealed and in date.

We saw stickers on equipment with service dates on which provided assurance that the equipment had been PAT tested, regularly serviced and conformed to relevant safety standards.

Maternity

The service had suitable facilities to meet the needs of women's families. The maternity department had a dedicated drop-off bay in front of the building to allow maternity patients to have easier access. There was also a quiet area/ bereavement suite for families who required quiet reflection.

The service had enough suitable equipment to help them to safely care for women and babies. The trust had a range of equipment to monitor women and their babies. We saw equipment, such as blood pressure machines and cardiotocography (CTG - to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour) machines were up-to-date with servicing and safety testing. We also looked at a random sample of consumable equipment, such as syringes and needles, which were found to be in good condition and in date.

Staff disposed of clinical waste safely. We observed that staff disposed of clinical waste including needles and domestic waste correctly. Staff ensured that all waste receptacles including sharps bins were not overfilled. A review of 5 sharps bins on the wards indicated all were clean, dated and not overfilled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The trust used Maternity Early Obstetric Warning System (MEOWS) to detect the deterioration during pregnancy, delivery and postnatal.

The provider had implemented individual growth charts and the International Federation of Gynaecology and Obstetrics (IFGO) cardiotocography (CTG) assessment model for intrapartum fetal monitoring following external reviews into intrauterine deaths. Records showed staff completed growth charts at every antenatal appointment and staff completed the IFGO assessments for CTG monitoring when this was undertaken. A fresh eyes and ear initiative was in place for peer review of CTG monitoring with stickers for staff to complete and attach to records. We saw staff correctly completed this process in our review of antenatal records.

Staff were required to complete additional training for their roles for fetal monitoring, and gap and grow. Gap and grow monitors the size of the baby and plots this on a graph to indicate whether the baby is within an expected size range, smaller or larger. The trust board papers for September 2021 demonstrate that 94% of midwives and medical staff had completed fetal monitoring training in August 2021 and 98% of staff had completed the gap and grow training.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Midwives completed risk assessments at the pregnancy booking appointment and streamed women to consultant-led care if risks were identified. Clinicians reviewed the risk assessments during each appointment or care episode.

Staff completed individual risk assessments on admission to the delivery unit. These included Venous Thromboembolism (VTE), which staff had completed correctly in the medical records. We found there had been an improvement in the completion of these safety tools since our last inspection.

Staff knew about and dealt with any specific risk issues. Staff completed regular clinical observations and risk assessments for women in pregnancy and in labour. This enabled staff to detect anomalies, sepsis and individual risks early. Midwifery and medical staff had training to complete neonatal screening. The postnatal ward completed this screening 6 hours after the birth.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service had a specialist continuity of care midwifery team, this team was responsible for the care of complex pregnancies where due to mental health or safeguarding concerns. Staff had access to support from these specialist teams.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff followed the local guideline in place for mental health referrals if staff were concerned that a woman had deteriorating mental health concerns.

Staff shared key information to keep women safe when handing over their care to others. Staff shared learning and key messages about safety critical incidents or issues within the environment during the handover process and again within safety huddles.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed midwifery and medical handovers, staff provided a comprehensive account of the care provided using the Situation, Background, Assessment and Recommendation (SBAR) model.

Maternity services had an escalation guideline in place for staff to follow in the event of a major incident or staffing shortages.

Maternity theatres completed the World Health Organisation 5 steps to safer surgery checklists for all surgeries. Patient records we reviewed for women who had caesarean section deliveries demonstrated that staff had completed the checklist. The service completed monthly compliance audits for the completion of the WHO checklist. We reviewed the audit results from August 2021 to July 2022 which demonstrated that the maternity theatres had achieved 100% compliance throughout this period. This met the trust's WHO checklist compliance target of 90% consistently.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The trust had challenges with the recruitment of midwives due to the national shortage in this staff group. This was highlighted at our last inspection. Managers told us they had a recruitment plan which was actively in progress which included international recruitment, return to practice midwives and increasing the number of student midwives. The trust had invested in a Deputy Head of Midwifery for Workforce and Education role to provide dedicated resource to support the successful recruitment and retention of midwives for the service.

On the day of our inspection a staff member from the ward was moved to the delivery unit for their shift due to staff shortages.

Staff reported that they struggled to take breaks especially on night shifts and we were told that none of the midwives on the night shift before we visited had a break. Staff we spoke with told us they were concerned as this increased the risk of errors, they could not always provide the care they wanted to, and something could be missed.

Daytime staff told us local managers were visible, supported staff, would relieve staff for breaks and cover staff shortages if alternative arrangements could not be made. However, this was not available for night staff.

Managers accurately calculated and reviewed the number and grade of midwives, nurses, midwifery assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust and maternity managers regularly reviewed staffing. Staffing was also reviewed following the Ockenden report. This meant that the service needs were changed, and the trust needed to recruit additional whole-time equivalent midwives. Staff moved between antenatal and postnatal wards and the delivery unit to meet the needs of the women in each area. The community midwives could also be required to cover in the unit.

The trust had an in-date version-controlled maternity escalation policy for staffing and capacity. The policy included an escalation procedure flow charts which were Red, Amber, Green, Black coded. Black would indicate unit closure.

The number of midwives and healthcare assistants did not match the planned numbers. A review of the data received after the inspection showed the trust had an establishment full time equivalent (FTE) of 104.7 midwives in the delivery suite and maternity wards and 116.7 including those in management positions. The number of midwives in post fell below this level at 81.83 FTE. There were also a lower number of maternity care assistants and support workers than the trust had planned for. A review of staffing acuity data after the inspection indicated that for the 3 months from 2 May 2022 – 31 July 2022, the staffing acuity was met 79% of the time. This was a 10% improvement from the 2021 staffing figures, but still showed 21% of occasions when there were not enough staff on shift. The trust provided data to show they increased permanent staffing numbers by using bank and agency staff. However, this still resulted in an average staff shortfall of more than 4 midwives a day. They trust had also recently recruited staff from overseas to help increase the numbers of permanent midwives.

The service had high vacancy rates. A review of data received after the inspection demonstrated the maternity service had a vacancy rate on the delivery suite, the maternity ward and outpatient department of 29% in June 2022 against a trust target of less than 5%. The service had a midwifery workforce predictor in place for 2023. The baseline midwifery staff in place as of June 2022 was 252.76 whole time equivalents (WTE), the forecast of midwifery staff in post March 2023 was 299.50 WTE.

The service had higher than average sickness rates. Nursing and midwifery staff on the delivery and maternity wards had a sickness rate of 7.82% in July 2022 against a trust target of less than 3.25%.

Managers used bank and agency staff and requested staff familiar with the service. Managers we spoke with told us that they had regular bank staff that were familiar with the service. The service also had regular agency staff who had completed a full orientation to the service.

Managers made sure all bank and agency staff had a full induction and understood the service. The service used regular agency and bank staff and booked shifts in advance. All bank and agency staff had a local induction to the clinical area which was documented. The induction was structured and included passwords to allow access to all the relevant information technology (IT) systems.

The service had an agency midwife pre-employment clinical checklist to assess the previous clinical experience and areas the midwife had previously worked in, for example, delivery suite.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe. This was an improvement since our last inspection. The service had a skill mix of doctors including junior doctors, middle grade and consultant obstetricians to care for women. The recommended consultant hours were met by the service. Consultants held ward rounds every day supported by junior medical staff.

Staff on the midwife-led triage unit and midwife-led day assessment unit both told us women sometimes had to wait for review from medical staff. They had to bleep the delivery suite doctors to attend when needed.

The medical staff matched the planned number. Medical staff told us they were fully staff in Maternity, although they were sometimes asked to cover other areas, such as Gynaecology, which put added pressure on to the workforce. Data from the trust showed working medical staff matched the planned number of medical staff.

Sickness rates for medical staff were low. Review of the data after the inspection showed there was a very low sickness rate. At the time of our inspection there was only 1 medical staff member on a phased return to work, with no other staff sickness.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants completed rounds 7 days a week and were supported by a team of speciality registrars and junior doctors. There was always an anaesthetist available for the delivery suite. A newly appointed consultant supported the service manager with rota planning to balance service and training needs for medical staff. This ensured there was an appropriate skill mix of staff available.

The service always had a consultant on call during evenings and weekends. The service had a consultant available out of hours. We saw the consultant on call overnight was already on the ward and preparing a woman for a caesarean section when we visited the delivery suite.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive and all staff could access them easily. We reviewed 5 sets of maternity records, all records were completed fully with a summary for each care episode both in the community and in the hospital. We saw there had been an improvement in the recording of risks factors in records, entries were signed and dated and the records were kept in a more orderly way.

When women transferred to a new team, there were no delays in staff accessing their records. Women had handheld records which they took to all clinical appointments or when accessing care from other services.

Records were stored securely. Women's records were stored securely in staff areas of the clinical areas within lockable record trolleys. This meant that information about women accessing care was available to staff.

Medicines

The service generally used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The trust used electronic medicine records for women in hospital. Prescription records we reviewed indicated staff had administered most medicines in line with the prescription. However, we found there were missed and late doses of a medicine to prevent blood clots for one woman. Another woman had been prescribed an antibiotic, which was no longer required, however it remained prescribed on the electronic system. We raised these concerns with midwives during our inspection.

The trust did not have patient group directions (PGDs) in place for midwives, however, the midwives administered under the midwife exemptions.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. We saw that midwives completed pain assessments before administering pain relief to women. This included assessing the severity of the pain and if any medicines were due. We saw that midwives checked women's names before administering medicines.

Staff completed medicines records accurately and kept them up-to-date. A record review on the electronic prescribing system initially indicated if a woman was overdue for her medicines for a non-maternity related condition, however, women were able to self-administer medication. Staff told us that women rarely chose to do this and preferred staff to administer all medication.

Staff stored and managed medicines and prescribing documents safely. Medicines storage temperatures were recorded and seen to be stored within an acceptable range.

An inspection of the medicine storage areas showed controlled medicines were stored in an appropriate medicine cupboard and controlled medicine log books were up-to-date, without any omissions. The nurse in charge held the medicine cupboard keys.

A random sample of medicines were checked and most were in good condition, in date and stored appropriately. We did, however, find an out-of-date Measles, Mumps and Rubella (MMR) vaccine in one fridge. We alerted staff to this.

Staff learned from safety alerts and incidents to improve practice. Managers provided information about safety alerts and incidents within maternity services during handovers and safety huddles.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

Staff knew what incidents to report and how to report them. Staff we spoke with knew how and what types of incidents to report through the trust's electronic reporting systems.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Managers we spoke with told us that staff reported incidents in line with trust policy, a review of incidents reported by staff confirmed this.

Managers shared learning about never events with their staff and across the trust. The trust shared learning from across the hospital in various formats, including posters and newsletters. A midwife told us they received a monthly newsletter that contained updates following incidents and changes made as a result of incidents were communicated through email, noticeboard or during handover of shifts.

Staff understood the duty of candour. They were open and transparent, and gave women and families a full explanation if and when things went wrong. Duty of candour was covered in the obstetric mandatory training day. Staff gave us examples of the practice of duty of candour and understood the importance of duty of candour. The senior midwife or clinician would take responsibility for duty of candour once the incident had been reported.

Staff met to discuss the feedback and look at improvements to patient care. The Head of Maternity informed us that senior staff met each week and reviewed all moderate or higher rated incidents. They confirmed there were approximately 60 outstanding incidents to be looked at. Senior managers reviewed these incidents on a weekly basis.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service coordinated care with other services and providers.

The service has a lead perinatal mental health midwife and a named consultant lead. This team was responsible for the care of complex pregnancies due to mental health or safeguarding concerns. The service also had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service also has the OCEAN mental health service (Offering Compassionate Emotional Support for those Living through birth trauma & birth loss). This included access to an integrated maternity and mental health service providing support for those affected by birth loss or birth trauma. This service was provided in partnership with the local mental health trust. Staff had access to support from these specialist teams.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women were able to access telephone triage services from 7am to 8pm Monday to Friday. The operational triage (which was available 24 hours daily) consisted of one room on the

delivery suite, where women received an initial assessment to identify the correct pathway. Triage was supported by the delivery suite coordinator in the absence of a dedicated triage midwife or when acuity was high, which placed additional pressures on the service. The coordinator was expected to review the woman on arrival and make an assessment of the treatment needed. The midwife would then refer woman to the correct care pathway.

Managers and staff worked to make sure women did not stay longer than they needed to. We saw that staff had meetings 3 times a day to consider whether women needed to stay on delivery suite or the combined antenatal/ postnatal ward. Women were discharged home from the delivery suite if this was appropriate for them. This meant that beds became available on a regular basis and women were able to go home as soon as possible.

Managers and staff started planning each woman's discharge as early as possible. Staff recorded key information, such as the type of birth a woman wanted, whether they intended to breast feed, whether they had other children or problems with previous pregnancies when they first registered antenatally. They were then able to anticipate how long women may need to stay at the service when they delivered their babies.

Women were referred to the service either through their GP or through the community midwives. Women could also self-refer using the trust's website.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. Women told us they knew who to contact if they were not happy or wished to raise a concern.

The service clearly displayed information about how to raise a concern in patient areas. We saw information about PALS (the patient liaison service) was displayed on noticeboards in the combined antenatal/postnatal ward. Contacting PALS was the first step for people to take if they wanted to make concerns known.

Managers investigated complaints and identified themes. Information about the number of complaints and concerns made was discussed at Clinical Quality Governance meetings, where themes and trends were also discussed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback about complaints was shared with staff during ward meetings. These were also used to share new learning and changes that was identified during the complaint investigation process

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Maternity

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders at every level had the experience and capability to deliver effective leadership of the service.

Although we saw an improvement since our last inspection, we continue to have concerns about mandatory and safeguarding training, and staffing levels. The trust had taken some action but not enough to ensure midwifery staff in particular had completed required training. They had also taken action to increase the number of midwives employed but we saw there were still times when there were not enough staff to allow staff to take breaks during their shift. We have told the trust they must improve this.

The trust had a defined leadership structure with a director of midwifery, general manager and clinical director (women's) at senior level, who were the direct line of reporting for the local care unit managers. Leaders told us they had ready access to and meetings with the executive team, with direct reporting lines to the medical director and chief nurse**.** This senior leadership team spoke with pride about the work and care their staff delivered each day.

The trust also had a management structure at a local (hospital) level. Medical staff reported to the clinical director.

Leaders at every level were visible and approachable. Staff told us the service leaders and line managers were supportive and they felt able to approach the leadership team openly and honestly.

The leadership at all levels was knowledgeable about the issues and priorities for the service and understood the challenges and had action plans in place to address the concerns.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Prior to the trust merger the service had a strategy document under the women's and children services. As the maternity services were now delivered across 2 hospital sites, the teams were developing a new maternity strategy across both sites.

The development of the strategy will involve all relevant stakeholders including staff and service users. The service has a phased approach to ensure effective engagement and planning. They are currently in phase 1.

The service had a set of values which were described by the acronym THRIVE. Teamwork, Honesty and openness, Respect, Inclusivity, Valuing people, Excellence.

Staff had a small card with the values on and the behaviours expected and how this was achieved. For example, Respect could be demonstrated by taking the time to actively listen and respond to patients, colleagues and carers. We observed posters with the values displayed, which had gone someway to meeting the Ockenden report recommendation that staff awareness of the vision and strategy be increased.

Maternity

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt well supported, respected, and valued by their managers and the senior leadership team. We saw positive interactions and working relationships between medical and midwifery staff. They reported collaborative and effective team working, which was evident during our inspection**.** This was an improvement since our last inspection.

The culture regarding duty of candour was positive. Where incidents had caused harm, and met the requirement for duty of candour, we saw that the appropriate action was taken. Staff also described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the woman and her family.

The trust had a Freedom to Speak Up Guardian. Staff we spoke with were aware of this role. The trust had received 9 requests in relation to the maternity service at Bedford Hospital in the 12 months prior to our inspection. None of these requests related to patient safety.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust held a monthly cross-site performance, safety and quality review meeting. This meeting had a standard agenda and was attended by midwifery and clinical representatives from both sites as well as the trust clinical director and director of midwifery. A review of the May and June 2022 minutes indicated updates were given from the local representatives as well as from trust level. Actions were clearly highlighted and the minutes included an action log.

Effective processes were in place to review incidents and risks. An incident and risk meeting was attended by members of the multidisciplinary team including obstetric, midwifery and the risk management leads. We saw that incidents and risks were fully discussed, action plans developed, and learning shared with staff through newsletters, emails, handovers and safety huddles.

Ward meetings were held in some areas of the maternity department. We saw that there were regular monthly triumvirate meetings which had an action log. The log included comments, actions, deadlines and updates. Items on the log included staffing challenges.

Regular face to face staff meetings had been suspended during the pandemic, however, we were told these were now being re-started. The service had put regular email contact, newsletters and electronic messaging in place to keep staff updated and informed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Maternity

The service had a maternity risk register which included a red, amber green (RAG) rating, description of risk, action taken, risk owner and review date. The risk register included the risks that we had been informed of as part of the inspection including staffing levels, staff mandatory training and the triage area.

The local Obstetric governance meetings discussed identified risks and action taken or in progress. Review of meeting minutes indicated risk was discussed and shared at the trust governance meetings, and included updates from governance, finance and human resources.

The service had an electronic incident reporting system. All staff were encouraged to report incidents and risks on the system. Data reviewed after the inspection indicate the service had 169 open notifications currently under review. Seventy-nine of these were overdue and 40 were waiting final approval. All incidents graded as moderate or severe harm are reviewed weekly in a multidisciplinary setting.

The trust had developed a newborn abduction policy and staff took part in drills, so they knew what to do in the event this should ever occur.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust has plans for an integrated IT system across both hospital sites. Managers within maternity services were keen that any electronic system that was used would ensure that the data quality met the needs for reporting internally and externally.

The trust used paper patient records, one set of records was held by the woman and the other by the service. The risk associated with tracking and scanning patient notes was on the risk register. The service did have an electronic prescription and medicine management system. The service had plans to move to electronic patient records in the future.

Local and trust service leaders demonstrated that they understood the performance of the maternity service which included women's and staff views, safety and risks. Managers had a framework to oversee the quality and safety of patient care, which included the maternity dashboard and the regular audit programme.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service consistently worked to gain feedback from staff, service users and external stakeholders. Managers communicated important messages to staff through safety huddles, handovers, staff meetings and through the monthly risky news newsletter.

Maternity

The service had feedback mechanisms in place to gain the views of women including feedback forms, formal complaints and the friends and family test. The latest friends and family test results we saw displayed on Orchard (antenatal/ postnatal) ward notice board showed feedback was improving.

The service had actively sought to engage with the local community and had close links with the Luton and Dunstable Hospital African mothers support group. They had plans in place to hold meetings in community locations to enable local engagement with women.

The service worked with the maternity voices partnership and were members of the Bedford Luton and Milton Keynes (BLMK) health and care partnership. The BLMK had hosted a webinar which was available to the local community and had experts to answer questions including those about pregnancy, breast feeding and the COVID-19 vaccines in pregnancy.

The leadership at both local and trust level were committed to developing a service which was designed to meet the challenges of the local community and to ensure the voices of the staff and all relevant stakeholders were heard.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Service leads continued to be committed to developing the service and were working towards a trust wide integrated team with pathways aligned across both hospital sites.

The service had safety champions in all clinical areas of maternity services. Safety champions had regular meetings and discussed topics related incidents and assurance measures.

The service had increased the number of obstetric consultants to provide additional consultant presence on site. This meant that the trust had exceeded the RCOG recommendations for consultant hours.

There had again been some improvements since our last inspection in 2021, although we continue to have concerns around staffing and triage, which had been flagged as areas for improvement since our 2018 and 2021 inspections.

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Urgent and emergency services

Good ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

Mandatory training was not completed by all staff.

Staff did not always keep up to date with their mandatory training. The trust target for mandatory training completion was 90%. The overall completion for mandatory training for all staff groups in the emergency department was 80.21%, which was below the trust target. The mandatory training included a range of topics, such as infection prevention and control (IPC), adult and paediatric basic life support, and safeguarding adults and children.

Information provided by the trust following our inspection showed that the overall completion of IPC training was 75.6% for nursing staff and additional clinical staff. Medical staff compliance with IPC training was 70.69%. This was below the trust target of 90%.

The completion of training in the recognition and treatment of sepsis was 69% for adult nursing staff and 74% of paediatric nursing staff. The completion of training in sepsis recognition and treatment was 56% for medical staff on tiers two to four.

We requested training compliance data for nursing and medical staff that have completed paediatric life support, advanced paediatric life support and trauma life support/ basic and advanced life support. As part of mandatory training staff completed level 2 adult and paediatric basic life support.

Overall training compliance with adult basic life support for nursing staff working in main ED was 64% and those working in paediatric ED was 60% . Medical staff compliance was 46.3%. Completion rates for paediatric basic life support for nursing staff was 69% for those working in general ED and 90% for those working in paediatric ED. Medical staff compliance was 24.32%.

The trust had an action plan to improve mandatory training compliance by December 2022. This was being monitored by the quality committee.

Clinical staff completed tier one training on recognising and responding to patients with dementia. Overall compliance with tier one dementia training was 91.46% for nursing staff and additional clinical staff. Overall medical staff compliance was 88.37%. Tier two dementia training was available to nursing and additional clinical staff in adult ED. Overall compliance was 55.95%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received regular reports of mandatory training completion and informed staff when their training was due.

Urgent and emergency services

The COVID-19 pandemic had impacted on staff capacity to complete mandatory training, some of which required face-to-face contact. The trust addressed this and introduced online mandatory training. Some staff we spoke with told us they found it hard to find time to complete their mandatory training during their working hours. Service managers were aware of the issues with mandatory training compliance and had developed plans to improve completion rates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not enough staff had training on how to recognise and report abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff in the paediatric ED and reception staff were able to access the central system which identified any known safeguarding issues or social services input. Staff used particular symbols on the front sheet of patient records throughout the department in order to discreetly identify when there were safeguarding issues. During our inspection, we saw that staff identified and escalated safeguarding concerns in relation to a patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff reported close working relationships with the lead nurses for safeguarding adults and children, who they contacted for support and advice as required. Staff were aware of the trust's safeguarding process.

Not all nursing and medical staff received training specific for their role on how to recognise and report abuse. Data supplied by the service following our inspection showed that overall completion of level two safeguarding adults training was 83.9% for nursing and additional clinical staff. Medical staff completion was 78.45%. Completion of level two safeguarding children's training was 89.57% for nursing and additional clinical staff. Completion of level two safeguarding children's training was 83.62% for medical staff.

Completion of level three adult safeguarding training was 57.14% for nursing staff. Medical staff compliance with level three adult safeguarding training was 28.57%. Completion of level three children's safeguarding training was 52.18% for nursing and additional clinical staff. Medical staff compliance with level three children's safeguarding training was 50%. The trust had an action plan to improve mandatory training compliance by December 2022. This was being monitored by the quality committee.

Staff informed us that safeguarding training was provided as part of the induction to the trust.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning was carried out against schedules and cleaning records reviewed were up-to-date and demonstrated that all areas were cleaned regularly. We observed staff routinely cleaned equipment after patient contact.

Staff told us that the infection control link nurse completed monthly audits of the cleaning folder documentation. The outcomes were shared with the matron. We saw evidence that any non-compliance with cleaning schedules was escalated from floor to board meetings with action plans required.

Data provided by the trust following our inspection showed that a monthly cleaning audit of resus and majors completed on 2 August 2022 demonstrated 96.32% compliance. A cleaning audit of paediatrics, minors and other departmental areas completed on 2 August 2022 showed 97.17% compliance.

Staff carried out key audits on a daily basis in areas such as hand hygiene, cannulas, documentation and pain. This encouraged staff to take ownership of service performance to drive improvement in standards.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as disposable gloves and aprons. PPE was readily available in all clinical areas. Staff adhered to 'bare below the elbows' principles to enable effective hand washing and reduce the risk of spreading infections. Hand sanitising units and handwashing facilities were available in all areas.

At the time of our inspection, the service carried out lateral flow tests on the majority of patients who attended the ED to test whether they were likely to have been infected with COVID-19. Staff were assigned to undertake swabbing of patients at the beginning of the shifts. Results of the tests had to be received before patients could move to other areas of the hospital. This was to ensure patient safety throughout the rest of the hospital. There was a side room in majors that could be used to isolate patients with infectious disease.

Environment and equipment

The design, maintenance and use of facilities, premises did not always keep people safe.

The design of the environment did not always follow national guidance. At the time of our inspection, there was ongoing building work taking place within the department. This had an impact on the day-to-day functioning of the department. Some areas had been moved and the use of space had been adapted to best meet the needs of patients with the environmental resources that were available. The work was expected to be completed at the end of 2022. The plans for the department were to increase the capacity within the department, as well as improve patient experience with state-of-the-art environment and equipment.

The same day emergency care (SDEC)/minor injuries area did not have piped oxygen and there was no wheelchair accessible toilet. This was a known risk which featured on the department's risk register, and the leadership team had a plan to address it. Patients were streamed to this area only if it was safe to do so.

The fit to sit/mini majors area had two cubicles with two chairs in each cubicle. Two patients were often placed in one cubicle at the same time, which we found limited patients' privacy. There was a separate examination cubicle which patients could be taken into when they needed to be seen on their own. This was one of the areas of the department that will be rebuilt. Staff in this area were responsible for monitoring the patients and they assessed whether they remained 'fit to sit'.

The waiting area was a relatively small, narrow space. The size and capacity of the waiting area was due to increase with the completion of the ongoing building work. The streaming nurse was able to have sight of the waiting area. At times when the department was facing increased demand, patients could be found queuing outside the doors to the department. A temporary shelter had been erected to keep patients waiting outside dry. The service used video monitoring equipment in the waiting area and the area outside the department, which was visible to the streaming nurse and reception staff. This meant that if a patient deteriorated, staff were able to respond promptly.

The trust had a designated room for patients who attended the department whilst experiencing mental health crisis. The room had an accessible alarm system. However, at the time of our inspection, we found there was exposed wiring on the wall, which presented a potential risk to patients. We escalated this to the nurse in charge on the day of our inspection who informed us they would raise it with the hospital estates and facilities team. The room met requirements in all other areas.

The service did not always have enough suitable equipment to help them to safely care for patients. We found four monitors in paediatric ED that were out of date for portable appliance testing (PAT) testing. Three of the monitors were due to be tested in May 2022, one of them was due to be tested in April 2021. We escalated this at the time of our inspection. Leaders told us that these items of equipment were immediately removed from use. There was planned maintenance for all equipment, however leaders told us there had been a delay in some of the maintenance being completed.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed four resuscitation trolleys. The trolley in majors had 13 dates in July 2022 that had not been checked. We reviewed three resuscitation trolleys in resus. These records showed staff completed all daily checks in July 2022 apart from one trolley where two dates were missed. The equipment on the trolleys was in date and serviced.

Staff disposed of clinical waste safely. Staff carried out waste segregation in line with trust policy. Staff labelled sharps bins and had not overfilled them.

The mental health room in the adult ED was situated immediately next to the nursing station, which allowed good oversight of the patients who needed to make use of the room.

The service had a designated children's area which maintained children's safety. The mental health room in paediatric ED was close to the nursing station, it was not the intended mental health room, but it had been made safe and staff told us children were supervised as required whilst using the room. Any potential ligature points had been locked away in built-in cupboards.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Patients who self-presented at the ED were greeted by a streaming nurse. The nurse was an experienced registered nurse who took down a brief description of the presenting complaint and then directed the patient to the most appropriate service. Patients arriving by ambulance used a dedicated ambulance entrance and were brought straight through to majors upon arrival when there was capacity. If there was no capacity in the department, the ambulance crew provided staff with a handover, however the patient remained with the ambulance crew on the vehicle. Nursing staff prioritised patients to be seen in order of clinical need and established if they were fit to sit in a chair to wait for treatment or if they required a trolley.

Hospital ambulance liaison officers (HALO) employed by a local NHS ambulance service worked alongside the ED team to support patient flow. This gave the opportunity to pre-alert staff if a patient required additional support and direct patient flow through the ED.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score system (NEWS2) for adults and paediatric early warning scores (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient.

Information provided by the trust following our inspection informed us that nursing staff completion of NEWS2 training was 71%. Paediatric nursing staff completed paediatric intermediate life support (PILS) which included PEWS. The completion rate was 74%. There was no specific NEWS2 or PEWS training provided for medical staff. However, NEWS2 and PEWS training was provided to medical staff in other modules.

The ED was in the process of rolling out electronic observations which used an alternative paediatric early warning score module (POPS), while they were awaiting the outcome of the national consultation on PEWS. The trust initially trained paediatric nursing staff to use the new system prior to the planned start in September 2022. The trust planned to deliver the training to the rest of the ED nursing and medical team after this time.

Nursing staff used a nationally recognised triage tool when completing initial patient assessments. Information provided by the service following inspection showed that from August 2021 to July 2022 the service consistently triaged less than 30% of its adult patients within 15 minutes of arrival. Adult triage figures fell to 22.26% in March 2022, and declined again to 18.49% in July 2022. Data showed that the service triaged 72.62% of paediatric patients within 15 minutes in August 2021. This figure steadily fell to 41.64% in July 2022. Staff told us that the most unwell patients were prioritised for triage.

We found that there was a lack of a formal process to ensure there was oversight of the waiting area to ensure patients were safe to wait for treatment. Intentional rounding is a structured process whereby staff carry out regular checks of patients using a standardised protocol to assess issues such as positioning, pain and personal needs. Intentional rounding was carried out throughout the emergency department, but not in the waiting area. We escalated this to the trust at the time of our inspection. We received feedback from the trust following our inspection confirming that intentional rounding for patients had been extended to all areas of the department, including the waiting room, at set times through the day and night. This was implemented immediately.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Medical staff completed an initial assessment of patients. Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. We reviewed ten sets of patient records and found that risk assessments were completed as required and actioned appropriately.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening condition when the body's response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff confidently described the signs of and what treatment should be initiated in line with national and local guidance. This included completing the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner.

The service carried out quarterly sepsis audits to monitor compliance. Audit results for October 2021 to December 2021 showed that 76% of cases received antibiotics within one hour of diagnosis. The service highlighted cases where there were delays in receiving antibiotics within one hour to the sepsis board.

We reviewed five sets of adult patient records and five sets of paediatric patient records. We found that although no patients met the threshold for triggering the sepsis pathway, it was only documented in one paediatric patient's notes that the patient did not meet the threshold.

The service had 24-hour access to mental health liaison and specialist mental health support. The service had support from an onsite psychiatric liaison team who offered specialist support and advice. There was specialist support for adults and children during the day, and an on-call consultant out of hours, who would cover adult and paediatric ED.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the psychiatric liaison service should they have any concerns, and there was a timely response to assess patients. Staff described a collaborative working relationship with the local mental health trust who were based on the hospital site.

Nurse staffing

The service did not always have enough nursing staff and support staff. However, managers regularly reviewed staffing levels and skill mix to keep patient safe. Managers gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Staff told us that actual staffing levels did not always meet planned staffing levels, particularly at night. The trust board papers from July 2022 showed that fill rate in adult ED was consistently below expectation from December 2021 to March 2022 at 90% or below. Fill rate steadily improved from April 2022 to June 2022 where 100% fill rate was achieved for day shifts. Fill rates in paediatric ED fell consistently below target fill rate from July 2021 to June 2022. Fill rate fell below 80% in December 2021 and remained steady until May 2022 where there was a slight improvement. Staff escalated staffing issues and there were processes in place to assess the risk, backfill staffing gaps from other areas or use bank or agency staff.

The service had undergone a recent recruitment drive and employed 55 new members of staff within the department, many of which were from overseas.

Managers were creative in trying to explore new ways of supporting nursing staff. Managers were aware that staff were exhausted, the department was consistently busy and staff often struggled to take their breaks. The service had run pilots to assess the effectiveness of new initiatives to support nursing staff. One of the initiatives was to trial a dedicated ambulance triage nurse for seven days. Managers were reviewing the nursing role and tasks that healthcare assistants and technicians could support with, for example support with triage.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Service leaders reviewed and flexed staffing levels at morning meetings and throughout the day to ensure staffing met the needs of the service and the patients, and was aligned to Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations.

The department manager could adjust staffing levels daily according to the needs of patients. The trust was licenced to use a new safer nursing care tool (SNCT). The SNCT calculated clinical staffing requirements based on patients' needs (acuity and dependency) which guided managers in safe staffing decisions. At the time of our inspection, SNCT reviews were taking place two times per day.

The service generally had low and reducing vacancy rates. Vacancy rates were higher in paediatric ED. The nursing vacancy rate was 5.36 whole time equivalent (WTE) in paediatric ED in July 2022. The nursing vacancy rate was 0.15 WTE in adult ED in July 2022.

The service had low or reducing turnover rates. Turnover in paediatric ED remained steady since January 2022 and was 4.44% in August 2022. Turnover rates in adult ED showed a generally reducing trend, however it was 11.68% in August 2022 which was an increase on the previous four months.

Sickness rates fluctuated in adult and paediatric ED over the last year. Leaders told us that COVID-19 had had a significant impact on staffing levels over this time. Sickness rates in adult ED were 6.25% in adult ED in July 2022, and 5.84% in paediatric ED in July 2022.

The service had low and/or reducing rates of bank and agency nurses. Agency staff use in paediatric ED was consistently low and was 0% in July 2022. The use of agency staff was higher in adult ED, at 4.87% in July 2022. Managers tried to limit their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

All the nursing staff working in the paediatric emergency department were registered children's nurses.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staffing met with Royal College of Emergency Medicine (RCEM) recommendations of 16 hours of consultant presence per day, seven days a week. A consultant was on call outside of these hours. The service employed one consultant who had formal accreditation in paediatric emergency medicine (PEM) in line with RCEM and Royal College of Paediatrics and Child Health (RCPCH) standards.

The medical staff rota covered the whole department, including paediatric ED. The only area that was staffed separately was the minor injuries department as it was located in a different area to ED while the redevelopment of the department was taking place.

Medical staff were rotated through the various areas of the ED depending on the workload and training opportunities in the areas.

The service historically had difficulties recruiting middle grade doctors, so they increased consultant cover to ensure there was enough medical staff. Managers could access locums when they needed additional medical staff for any unfilled shifts, for example, due to staff sickness. Managers made sure locums had a full induction to the service before they started work.

The service had low rates of bank and locum staff. Data supplied by the service showed the use of locum staff was lower than the use of bank staff. In July 2022, the use of locum staff was at 4% and the use of bank staff was 12.8%.

Sickness rates for medical staff were low and reducing. Sickness rates peaked at 5.46% in December 2021 and 4.09% in March 2022. They since reduced to 1.78% in July 2022.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The medical staff rota was well structured and organised. The rota was designed to provide two tier 2 doctors and six tier 3 or tier 4 doctors on each shift. The doctors on tiers 2 to 4 all worked on a three shift pattern of rotating early, late and night shifts. They started and finished every shift together. Shifts overlapped to give time for handovers and teaching in the afternoons.

The service had increasing vacancy rates for medical staff. Vacancy rates had reduced from 17% in August 2021 to 8.4% in January 2022, however vacancy rates steadily increased to 17.2% in August 2022.

The service had increasing turnover rates for medical staff. The turnover rate reduced from 34.37% in August 2021 to 17.39 in January 2022, however the turnover rate gradually increased to 37.14% in July 2022.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were up-to-date and easily available to all staff providing care.

Patient records were kept in paper format and some information was held electronically. When patients attended ED, a paper record was generated for use in the department. Requests for tests and diagnostics were made using the electronic system.

Patient notes were comprehensive and all staff could access them easily. We reviewed five sets of adult patient records and five sets of paediatric patient records. We found that appropriate risk assessments were completed, including frailty and skin assessments.

Any allergies were clearly documented. The service used relevant stickers on paper records for the sepsis six care bundle, suspected neutropenic sepsis and pregnancy.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients were not transferred elsewhere in the hospital for admission until they had been reviewed by the doctor who would be taking over their care. However, patients could be transferred immediately if they were going to the medical or surgical assessment units. Staff also had immediate access to the records that were held electronically.

Records were not always stored securely. We found that computers within the department were frequently left unattended and unlocked. This increased the risk of confidential patient information being witnessed or accessed by others. We discussed this with service managers and they informed us that the computers automatically logged out after 10 minutes. It took a long time for staff to log in, which was not suitable in a busy ED environment, however the computers were not left unattended for long. There were plans in place to update and improve the service's IT infrastructure.

We found that records did not always clearly state whether a patient met the threshold for the sepsis pathway. None of the records we reviewed triggered the pathway, however it was only documented in one patient's record we reviewed that the patient did not meet the threshold to trigger the pathway.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were stored in locked cabinets in locked rooms. Keys to access medicines were held by designated, qualified members of staff.

Urgent and emergency services

Staff reviewed patients' medicines regularly. Pharmacy staff provided support to the department and ensured medicines were restocked. The service could contact the pharmacy team for support when required, and there was a system in place to access support out of hours. There was a vacant post for a dedicated ED pharmacist due to recent staff development. The service was advertising for two posts so they could provide 12 hours cover to ED.

Staff completed medicines records accurately and kept them up-to-date. We reviewed a sample of prescription records which were completed appropriately.

Staff stored and managed all medicines and prescribing documents safely. We checked a range of medicines in different areas of the department. Medicines were stored appropriately and were within expiry date. Controlled drugs were checked daily to help ensure stock levels were correct.

ED used a paper-based prescribing system, whereas the rest of the hospital used an electronic prescribing system. This developed into a risk for the service, as at the time of our inspection, patients were spending longer periods of time in ED and needed to start medicines before moving to other areas of the hospital. This was featured on the risk register for the service, and leaders planned to move ED over to electronic prescribing in the future. The service provided feedback following our inspection to explain how the risk surrounding time critical medicines was being addressed. The service introduced a system to identify patients who were likely to require time critical medicines at triage, as well as following clerking by a specialty team. The plan was to then manage patients through intentional rounding and monitor compliance with this. In order to reduce the waiting time for triage, the department recently changed the allocation of triage tasks between nurses, HCAs and technicians to improve the efficiency of the process.

Is the service responsive?

Good ↓

Our rating of responsive went down. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. The service worked collaboratively with external agencies and partner organisations to improve services provided by the trust. This included working with commissioners, general practices and neighbouring NHS trusts to identify the needs for the local community.

Leaders regularly engaged with a variety of system partners. For example, the trust had close links with the local mental health trust and held regular meetings to ensure their services were aligned to appropriately meet the needs of the population. Leaders also attended monthly meetings with the local ambulance trust to discuss delays and how both services could work together to improve experiences and outcomes for patients.

Leaders explained that the service had introduced a silver phone system working with GPs, ambulance crews and other system partners. This meant they could speak directly to frailty staff within the hospital, receive advice and consider the patient’s care pathway, rather than sending patients into the ED if it was not required.

Urgent and emergency services

As patients were experiencing longer waits in the department, the service introduced power banks that patients could pay to use to charge their mobile phones, which was responsive to the changing needs of patients.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had a psychiatric liaison service based on site close to the department, so support could be accessed quickly. The service worked closely with police and the local mental health trust to ensure the pathway for mental health patients was clear and safe.

The service relieved pressure on other departments when they could treat patients in a day. The streaming nurse assessed patients on arrival to ED after they had booked in at reception. If appropriate, patients could be streamed to the GP service, to the minor injuries unit or to the same day emergency care (SDEC) area. This reduced the number of patients who needed to be assessed and treated in the emergency department.

The service worked with external partners to provide access to primary care services via the urgent GP clinic which was situated within the hospital site. This meant that patients could still receive assessment and treatment rather than being advised to try to make an appointment with their own GP surgery. There were approximately 500 patients a day presenting to the ED, and approximately 150 of those were streamed to the GP service.

Facilities and premises were adapted for the services being delivered. At the time of our inspection, the emergency department (ED) was in the process of being redeveloped. This meant that certain areas such as the waiting area felt cramped, however the plans for the department were designed to meet the needs of patients and increase the space and capacity of the department.

Access and flow

People could not always access the service when they needed it and did not always receive care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times, however not all patients could access emergency services when needed or received treatment within agreed timeframes and national targets. At the time of our inspection there was limited bed space in the wider hospital, which contributed to poor patient flow out of the emergency department, leading to significant delays in patients waiting to be seen and moving from the ED to the wards.

An early morning operations meeting took place where the service's situation report was reviewed. This included information such as number of attendances, breaches, patient flow, waiting times and performance. The report also indicated bed space and any significant staffing and capacity issues in other areas of the hospital to allow leaders to assess and plan accordingly.

The Department of Health and Social Care set a standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival to ED. This service was part of a national review into NHS access standards, where new standards were being piloted. The service continued to collect performance data regarding the four-hour standard. Information provided by the service following our inspection showed a mostly decreasing trend from 83.1% of patients in August 2021 to 75.3% of patients in July 2022 who were admitted, transferred or discharged within four hours of arrival. This corresponded with a general increase in attendances to ED within this timeframe, and the ongoing development work impacting on capacity within the department. Despite this, data we reviewed demonstrated that performance for patients waiting to be admitted from ED was much better than the England average.

Urgent and emergency services

Information provided by the service following our inspection showed that the number of patients seen within one hour by a specialist ranged between 14.87% and 27.89% from August 2021 to July 2022.

Information provided by the service following our inspection showed that in August 2021, no patients waited longer than 12 hours in ED. This increased gradually to 0.1% of patients in December 2021. This trend increased slightly until it peaked in July 2022 at 2.9%.

The number of patients leaving the service before being seen for treatments was low. In August 2021, 2.38% of patients left the department without being seen. This figure gradually decreased to 1.14% in January 2022 and then gradually increased again to 3.13% in July 2022.

The percentage of ambulances remaining at hospital for more than 60 minutes was 2.5% in August 2021. This steadily increased to 8.82% in March 2022 and then decreased slightly to 7.93% in June 2022. The percentage of ambulances offloading patients within 15 minutes of arrival steadily decreased from 45.95% in August 2021 to 31.95% in June 2022. This data was collated by the local ambulance trust. The service worked closely with the local ambulance service to improve delays with offloading. The ambulance service employed a hospital ambulance liaison officer (HALO) to support ambulance and hospital staff in ED to improve patient flow. The HALO could use intelligence conveyance if needed to divert vehicles to hospitals that were not as busy. They could also pre-alert staff if a patient required additional support.

The median time from arrival to initial assessment for emergency ambulance cases increased slightly from 17 minutes in August 2021 to 22 minutes in July 2022.

Managers and staff worked to make sure patients did not stay longer than they needed to. Nursing staff had access to a basic stock of medicines in premade to take away (TTA) boxes, which meant patients could be discharged without having to wait for pharmacy. This was a measure to help reduce patients' length of stay in the department as well as other areas of the hospital to help improve flow.

We observed teams working well together to manage flow within the department. We observed a flow meeting, which took place twice per day. There was representation from mental health, the local ambulance service and pharmacy, as well as the deputy director of nursing, the matron, an ED consultant and the deputy medical director in attendance. We observed supportive and collaborative discussions. There were also processes in place to escalate significant concerns or risks when required. There were collaborative discussions about hospital status and pressures in the community.

The service ran a week-long pilot with an ambulance triage nurse in place. A senior nurse was situated by the ambulance door and was able to triage patients immediately and carry out a detailed clinical assessment. The data from the pilot still required analysis at the time of our inspection, however initial findings showed that it reduced patients' waiting time on ambulances for triage. It also provided more assurance about the level of clinical risk, even if it had not been possible to offload the patient.

Managers told us the area where triage took place had recently moved to a four bedded area, which increased its capacity. Triage was staffed by two nurses, a technician and a healthcare assistant, whereas it had previously only been staffed by nurses. Managers told us this improved triage performance.

Is the service well-led?

Good ↓

Urgent and emergency services

Our rating of well-led went down. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department (ED) had a clear leadership structure. It was led by a general manager for acute and emergency medicine. This meant that the leadership team had oversight of areas in the wider hospital and awareness of factors that impacted on both services. The general manager worked across both Luton and Dunstable hospital and Bedford hospital and split their time evenly. The general manager was supported by the site-specific leadership team at Luton and Dunstable hospital. They were the clinical director, senior service manager and deputy head of nursing. The head of nursing post was vacant at the time of our inspection. Leaders understood the issues within the service and wider organisation and were active in their roles.

Leaders understood the challenges to quality and sustainability within the service and identified the actions needed to address them. For example, one of the challenges within the service was staffing of band five nurses within the department. Leaders spoke about it as a challenge during our inspection and it is also featured on the department's risk register. The risk was mitigated through recruitment, the use of regular bank and agency staff and daily staffing reviews.

Staff informed us that leaders were approachable and supportive, and also stated that leaders were visible within the department. Staff informed us that the leadership team provided support to manage patient care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for the department to be seen as an example of excellence by ensuring all patients received timely treatment, ensuring clinical standards were met, ensuring a multi-disciplinary approach to care, staff satisfaction and excellence in training and education. Leaders felt strongly that urgent and emergency care should be featured in the strategies of all other service lines to acknowledge how they considered and worked with ED. One of the main priorities of the service was to reduce the length of patient stay in the department.

The service developed an 'umbrella project' to address overcrowding in the department, which was aligned with achieving the service vision. The project was discussed at monthly service line meetings and included reviewing alternative pathways, such as GP referrals and same day emergency care (SDEC). The project also included reducing attendances where possible, ensuring an efficient triage process and flow through acute areas. The project was led by the general manager and involved partners in the relevant areas.

The majority of staff we spoke to were aware of the trust's vision and clinical strategy and could tell us what they were.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Urgent and emergency services

The culture of the service centred on the needs and experiences of patients who used the service. Leaders at all levels in the department told us that they were proud of the care their staff delivered and stated they had demonstrated notable resilience since the outbreak of the COVID-19 pandemic. Leaders commended staff for their unwavering commitment to patient care through extremely challenging circumstances.

Staff informed us they felt supported, respected and valued. Staff spoke positively about the service leadership; they told us leaders were always supportive and described an open culture. Senior nurses informed us they had frequent contact and support from the matron.

The department recently received 55 new members of staff, existing staff described great teamwork in welcoming and supporting the new staff members. New members of staff we spoke with told us they felt welcomed into the department.

All the junior doctors we spoke with told us they enjoyed working in ED, they said they felt supported and valued by their seniors and colleagues and that they had opportunities to learn and gain confidence. Staff told us there were good training and support mechanisms in place.

Due to the demands within the department, staff informed us that they sometimes felt they were not able to do their best for every patient.

Patients could leave feedback in several ways, including through local and national patient surveys, friends and family tests, through the patient advice and liaisons service (PALS) and by social media.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support achievement of the service's vision. There was a clear governance structure with regular meetings. Clinical service line meetings took place on a monthly basis and included quality and safety, operational performance, workforce, finance and priorities of the service.

All levels of governance and management functioned effectively and interacted with each other appropriately. The clinical service line meeting reported to the executive team in the executive review meeting. Performance information discussed in the clinical service line meeting was displayed on a performance board for staff to see. Nursing staff attended floor to board meetings where key information was disseminated and regular consultant meetings took place. There were processes in place for escalation to the clinical service line meeting if required.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. All staff we spoke with were clear about their roles and understood what they were accountable for.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Risks were captured on the service's comprehensive risk register which used the red, amber, green (RAG) system to denote the level of risk and progress in resolving the risks. There were robust arrangements for identifying, recording and managing risks, and mitigating actions. Staff were aware of the highest risks within the service, which included waiting times, ambulance delays, staffing levels and patient flow. This aligned with the risks that were captures on the risk register. The service had an up-to-date business continuity policy to provide continuity of services during any major disruption.

There were processes to manage current and future performance. The department collected performance data which was reviewed in the monthly clinical service line meetings and reported to the board. This meant that leads could review the performance of the service and identify areas of learning. The collated data was included in the report to the board.

The service had an internal and external audit programme to monitor quality and operational processes, as well as systems to identify where action should be taken. We reviewed the audits for infection control, neck of femur and pain in children. All audits had action plans in place to improve audit compliance. Audit results were shared with staff in local meetings. There were plans to re-audit as appropriate to monitor improvement.

Staff carried out audits on a daily basis in key areas such as hand hygiene, cannulas, documentation and pain. This encouraged staff to take ownership of service performance to drive improvement in standards.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Leaders and staff strived to achieve continuous learning, improvement and innovation. The trust developed an agreement with the local police force whereby the police could pre-alert the hospital that they were travelling to the hospital with a patient in the event of a medical emergency if there was no time to call an ambulance.

The service recently appointed two doctors into pre-hospital emergency medicine posts. The doctors spent 50% of their time working in the emergency department and 50% of their time working in the local air ambulance service.

The trust was involved in a joint venture with other community agencies to provide training to staff so that they could support vulnerable young people involved in street violence. Doctors and nurses from the emergency departments across the trust had signed up to the course. The venture was supported by input from the trust's deputy medical director.

The service took part in a 111 virtual waiting room project. 'Think 111 First' is a national programme that encourages patients who may need urgent emergency care to initially call NHS 111. By following this process, the programme aimed to book an ED appointment for patients if necessary, to help reduce the number of patients that attended the waiting area.

The service trialled the introduction of an ambulance triage nurse to try to reduce the time patients waited on ambulances. It enabled a senior nurse to triage patients immediately and carry out a detailed clinical assessment. Initial findings showed that it reduced patients' waiting time on ambulances for triage.

Medical care (including older people's care)

Good ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and generally made sure everyone completed it.

Nursing staff received and kept up to date with their statutory and mandatory training. Staff completed training online and in person depending on the type of training.

Compliance for equality, diversity and human rights, fire safety, moving and handling, health safety and welfare, and conflict resolution were all above the trust target of 90%.

However, compliance for some training renewed annually was slightly below the trust target for example infection prevention control 79%, information governance 76% and basic life support 76%. Overall training compliance for nursing staff was 87%. The service set a 90% compliance target for all mandatory training.

Mandatory training was comprehensive and met the needs of patients and staff. The training was aligned to the skills for health core skills framework and included all key topics. Staff completed sepsis training as part of immediate life support (ILS) training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff in all areas completed dementia training tier one and staff who regularly cared for people living with dementia completed tier two. Compliance for medical staff was 82% and 89%, nursing staff compliance was 92% and 78% respectively.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers used an electronic system and compliance reports to monitor when staff training was due and notified staff to complete the training.

Medical staff received and mostly kept up to date with their statutory and mandatory training. However, overall average compliance was lower at 73%. We raised this with managers who told us that mandatory training had been suspended during COVID-19 in line with national guidance.

Managers told us that training had recently been cancelled due to periods of extreme pressure in order to prioritise patient care, some ward managers had not been able to schedule time into rotas to allow staff to complete training due to staff absence and high vacancy rates. However, they had a robust plan to improve performance which included personalised email reminders to staff and meetings to support department leads.

Medical care (including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff did not always keep up to date with training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to explain how they would identify vulnerable adults. They provided us with examples including an elderly patient living alone who displayed signs of self-neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could clearly describe what a safeguarding concern was and how to make a referral. They provided us with examples of safeguarding referrals made, including a patient who had fallen repeatedly in a care home. They completed all the necessary steps according to internal policies and national guidance. We reviewed a safeguarding referral and found this to be completed correctly.

Staff had access to visual prompts on ward notice boards and safeguarding adult and children's policies on the trust intranet. The service had a designated adult safeguarding lead who staff could contact for advice.

Nursing staff received training specific for their role on how to recognise and report abuse. Compliance for safeguarding adults level two was 91% and safeguarding children level two was 90%, these were above the trust target of 90%. Safeguarding adults level three compliance was 80%, slightly below target. Safeguarding training included FGM (female genital mutilation) and Prevent (safeguarding against radicalisation) training.

Medical staff did not always keep up to date with safeguarding training. Compliance to safeguarding children level two was 86%, safeguarding children level three was 100% and safeguarding adults level two was 86%, however, safeguarding adults level three training was below the trust target at 66%. We raised this with managers who told us this was being addressed under the mandatory training recovery plan.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. They kept equipment and the premises visibly clean. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

Ward areas were clean and had suitable furnishings which were visibly clean and mostly well-maintained. Ward areas had dispensers of clean gloves and masks. Antibacterial hand gel dispensers were available, and posters prompted staff and visitors to clean their hands regularly. Each bay and side room had clinical handwashing sinks and a poster reminding staff of the five moments of hand hygiene.

The service generally performed well for cleanliness. Cleaning staff were trained on how to clean to minimise the spread of infection. Each ward displayed a star rating poster on the quality board which showed that cleaning had been completed, all areas visited were rated four or five stars. Audit data showed an average compliance of 95% for July 2022.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff worked to a detailed cleaning schedule on each ward. Managers audited cleaning standards and reported areas that needed to be improved.

Medical care (including older people's care)

Staff generally followed infection control principles including the use of personal protective equipment (PPE). At our last inspection we told the service it should ensure nursing and medical staff adhere to the trust policy of being 'bare below the elbows". At this inspection we found that staff were bare below the elbow and all grades of staff cleaned their hands regularly. Annual compliance for hand hygiene was 87% across medical wards and 92% for complex medicine.

However, we observed on one ward that staff did not always wear eye protection when caring for COVID-19 positive patients which was not in line with hospital policy. We raised this with managers who explained that eye protection was required only when undertaking procedures where staff were at risk of exposure to body fluids. Following our inspection, managers told us they had improved and undertaken staff learning events to further clarify policy.

Patients who had tested positive for COVID-19 were cared for on designated wards and within separate bays on further wards. Signage was used to identify areas with COVID-19 patients. However, on one ward we observed a 'Bay Watch' sign (which indicated enhanced observation was required) partially obstructing the signage on the main corridor alerting staff to a COVID-19 bay. We also observed staff using interconnecting doors between this bay and a bay which contained patients who were not COVID-19 positive. This increased the likelihood of cross infection. We brought this to the attention of the senior nurse who immediately addressed the issue.

Staff completed infection and prevention and control training, compliance was 79% for nurses and 100% for medical staff.

Ward managers completed infection control standard (ICS) audits including environment, equipment, dress code, hand hygiene, patient isolation, waste and management of cannulas and catheters. Medicine wards scored an average of 80% and complex medicine scored 78%. Compliance by ward ranged from 79% to 97% against the trust target of 95%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning equipment after patient contact. However, we did not see "I am clean" stickers being used consistently to label equipment to show when it was last cleaned. This meant that staff could not be aware of cleaning that had been completed. We raised it with ward managers who said new stickers would be used when equipment was cleaned.

Managers used ICS audits to identify areas requiring improvement for example 'I am clean' stickers not being used consistently (most wards) and eye protection not being worn by some staff (wards 18 and 19b). They used staff briefings to remind staff of the importance of standards.

The hospital used an infection control dashboard to monitor reportable hospital-associated infections (HAI). The hospital had appointed a consultant microbiologist as director of infection and prevention control (DIPC), they were accountable for internal and external quarterly reporting.

We reviewed data which showed there had been 44 hospital-associated infections on medicine wards and 49 on complex medicine from April 2021 to April 2022. The hospital had reported an increase in Clostridioides difficile (C.difficile) infections in the quarter from October to December 2021.

The infection, prevention and control (IPC) team had expanded their service to cover 7-day working which meant that staff were more easily able to access their support. They monitored performance and had plans to increase staff awareness using link practitioners, newsletters and an annual IPC meeting.

On review of environmental audits, we identified that staff had reported that the design of the taps on some wards did not allow staff to use a non-touch technique after handwashing.

Medical care (including older people's care)

Environment and equipment

Staff managed clinical waste well. The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Patients could reach call bells and staff responded quickly when called. We observed staff responding to patient calls in a timely way.

The service had suitable facilities to meet the needs of patients' families. Visitors were able to park and buy refreshments. The trust published visiting hours and rules on the trust website.

Staff disposed of clinical waste safely. Waste was separated and stored securely before being disposed of safely. Sharps bins were not overfilled and were correctly labelled.

The service had enough suitable equipment to help them to safely care for patients. The facilities team used an asset register to monitor when equipment was due for routine maintenance. This was generally well maintained, however, we found that some checks were overdue because equipment could not be located or was not available. Endoscopy staff planned lists within the endoscopy department to make sure there was enough decontaminated equipment in line with national guidance. Ward staff could usually access the equipment they needed to provide care. However, storage space was an issue on some wards, for example hoist equipment was stored in corridors which prevented adequate fire exit space.

Staff carried out daily and weekly safety checks of specialist equipment. Staff used handheld tablets to scan a bespoke barcode to complete daily and weekly checks of resuscitation equipment. Staff were alerted to consumables reaching expiry date and managers were alerted to any outstanding checks which allowed them to follow up with staff. We reviewed resuscitation equipment on 10 wards and found checks and equipment were in date. Staff in some areas experienced poor network connections for handheld tablets and reported a lack of desktop computers.

The design of the environment followed national guidance. However, St Mary's day unit did not have enough space or a waiting area for patients. Staff told us they used a booking system to make sure there was a chair for each patient, however, patients could be asked to wait outside the unit if there were delays. We brought this to the attention of managers who told us they planned to relocate this service to a larger area in October 2022.The facilities in ward areas and on corridors showed signs of wear and tear including damaged walls, doors, skirting and windows. Managers told us the trust had a refurbishment schedule; however, this had been delayed due to COVID-19 and extreme pressures on the service.

We observed and reviewed in meeting minutes that on some areas on wards, day rooms were used for the escalation inpatient beds. However, no suction or oxygen were available within these patient spaces. Managers mitigated the risk by making sure that patients with infections were not admitted to these areas and that portable oxygen and suction were available. This was reported on the service line risk register with a risk score of 16.

We identified that the emergency call bell was not located close enough to the shower areas on one ward. This meant that patients had no means of alerting staff should they fall in the shower. Managers mitigated the risk by using portable call bells, this was on the service line risk register with a risk rating of 9.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Medical care (including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS) system to identify and escalate deteriorating patients. We reviewed records and found these were mostly completed correctly and appropriately escalated for medical review.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff told us they liaised with the mental health team to review patients who were at risk of suicide or self-harm. The team reviewed the patient within 24 hours and formulated a plan which would consider future care and how discharge would be managed. Staff knew about and dealt with any specific risk issues. Staff were able to explain how they would assess patients for risk of falls using a multifactorial falls assessment and used 'Bay Watch' enhanced observation bays for patients assessed as high risk.

Specialist tissue viability nurses were able to explain how they supported staff to assess and care for patients with pressure areas in line with the trust pressure ulcer prevention policy. They would assess patients within 72 hours of admission and recheck every 72 hours using a pressure area risk assessment tool.

Staff completed risk assessments for each patient on admission, using recognised tools, and reviewed these regularly including after any incident. The trust had recently moved patient risk assessments to an electronic patient record. Staff were positive about this change and showed us how they were able to complete assessments with the patient using a handheld tablet.

Staff shared key information to keep patients safe when handing over their care to others. The service staff worked with discharge planners who liaised with community social care providers to ensure safe discharge.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information. Staff used a handover sheet to record key information when handing over care to other staff.

Staff completed a range of risk assessments for example falls, manual handling and venous thromboembolism (VTE). They used nationally recognised tools such as the Waterlow Tool to assess the risk of pressure areas and the Malnutrition Universal Screening Tool (MUST) to assess risk of malnutrition.

The service used the sepsis six pathway; however, this was documented in the care pathway as it had not yet been added to the electronic patient record. Sepsis and VTE were audited to ensure compliance.

The service did not currently pre-assess patients before an endoscopy procedure. Staff told us that they sent patients pre-procedure information which included instructions on how to take bowel preparation and when to stop medication. Endoscopy managers told us the service did not report a high number of adverse incidents, but they experienced high levels of cancellations on the day due to patient's not having correctly followed instructions. The service planned to introduce the pre-assessment pathway used at Bedford Hospital to reduce cancellations and improve the patient experience.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Medical care (including older people's care)

The service did not always have enough nursing and support staff to keep patients safe. Stroke services had over 10 nursing vacancies which put the service under extreme pressure. Managers told us that they were proactively recruiting into vacancies and matrons had been stepping in to backfill to mitigate the reduced staffing levels.

The ward manager could adjust staffing levels daily according to the needs of patients. However, the number of nurses and healthcare assistants did not always match the planned numbers. The trust used the safer staffing model to adjust the planned staffing numbers according to patients' needs.

The service had high and increasing vacancy rates. Data provided by the trust showed that vacancies had gradually increased from 7.5% in February 2022 to a high of 12.7% in July 2022. This equated to 69 FTE (full time equivalent) staff vacancies.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Matrons and ward managers attended a safer staffing meeting twice a day where they reviewed staffing to identify areas of concern and agree staffing moves needed to keep patients safe, the deputy director of nursing provided support and challenge.

Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank and agency staff use was an average of 12% and 5% (respectively) of total staff hours from February 2022 to July 2022.

Managers implemented alternative solutions, such as therapy staff supporting with activities for patients on care of the elderly wards. They were planning to introduce mental health support workers to assist with patients living with dementia and needing enhanced care.

Ward managers told us that they felt supported by matrons who prioritised nursing staff for areas based on patient acuity. Staff in acute medicine told us that they had good teamworking and regularly shared nursing staff.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes. The service had a stable turnover rate with an average of 13% of staff leaving each month from February 2022 to July 2022. Managers told us they saw the highest turnover in Band 5 nurses and health care assistants (HCAs).

The service had a stable average staff sickness rate of 5% across the same period.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Trainee doctors received support from a dedicated educational / clinical supervisor who was allocated before they arrived to their allocated ward department. Supervision was discussed at induction and during their initial supervision meeting. They were informed of who to contact in and out of hours.

Medical care (including older people's care)

The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

There was consultant available for each ward seven days per week until 10pm. After this time a consultant on-call team provided support 24 hours a day seven days per week. There was also a designated stroke consultant available 24 hours a day, seven days per week to support the Hyper Acute Stroke Unit (HASU).

At weekends there was a junior doctor on all wards and every ward had a consultant ward round.

The service had a turnover rate of 23% for medical staff in July 2022. This was an improvement on the average from February 2022 to June 2022 which was 23.5%.

Sickness rates for medical staff were low and were reducing. The service had a sickness rate for medical staff of 3.2% in July 2022. This was an improvement on average from February 2022 to June 2022 which was 3.7%.

The service had reducing rates of bank and locum staff. In July 2022 a total of 9.5 FTE bank staff and 29 FTE were used to support the contracted workforce. Both had reduced from an average of 11 and 36 respectively.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. At the time of our inspection, the service had 38 contracted consultants (FTE) and 3 vacancies.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes. Managers knew which wards were reliant on locum consultants and had plans to address this risk.

Junior medical staff had access to support and teaching and felt positive about ongoing development opportunities.

The service had a medical staff vacancy rate of 11.8% in July 2022. This equated to 31 full time equivalent (FTE) staff. This had increased from 24 FTE and an average of 9% from February 2022 to June 2022.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The trust used a combination of electronic and paper records. Staff documented care on a paper care pathway booklet, however, risk assessments, observations and medication were recorded on an electronic care record. We reviewed 32 records across 10 wards, most records were clear and up-to-date.

When patients transferred to a new ward/ team, there were no delays in staff accessing their records. The service had introduced systems to improve discharge for patients being discharged into a nursing home. Staff in acute medicine completed a transfer checklist and provided a body map (a visual record showing location of injury, for example pressure ulcers) and a separate letter to detail ongoing care plans, for example pressure area management. The patient's GP was informed by an electronic discharge letter and a system was in place to request district nurse visits.

Staff stored records securely. At our last inspection we found not all patient records were kept in locked trolleys to maintain confidentiality. On this inspection we found paper records were stored securely in trolleys or cupboards which were locked when unattended and electronic records were accessed using a unique login and password.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, they did not always store medicines correctly.

Staff followed systems and processes to prescribe and administer medicines safely. An electronic prescribing and medicines administration (EPMA) system was in place. Projects led by pharmacy staff were set up to work alongside ward staff towards the Greener NHS plan and medicines.

Staff completed medicines records accurately and kept them up to date using the electronic patient record. Managers told us this system helped them to check that patient's medication had been administered on time, we observed this in practice.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Clinical pharmacists regularly visited the wards, reviewed medicines and would speak to patients about their medicines when required. Patients were provided with specific advice on discharge where appropriate.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff visited the wards from Monday to Friday and staff knew how to access support from pharmacy outside of these hours. There was a process in place for prioritising patients including seeing patients that were newly admitted to the hospital. Staff had access to summary care records to support the process of medicines reconciliation (the process of accurately listing a patient's medicines they were taking at home and comparing it to what is prescribed whilst they are in hospital).

Staff learned from safety alerts and incidents to improve practice. The trust had an effective process for disseminating medicines safety alerts and sharing learning from medicines safety incidents.

Staff did not always store and manage all medicines and prescribing documents safely. On our last inspection we found inconsistencies in the monitoring and escalation of fridge and room temperatures exceeding the recommended range. On this inspection medicines storage temperatures were recorded, however temperature excursions were not always reported to pharmacy as per trust policy. Therefore we could not be assured that medicines were always safe and effective to use. However, when this was reported, pharmacy acted quickly to investigate and resolve. The pharmacy department were also taking steps to install controlled room temperature storage solutions to ensure safe storage of medicines stored at room temperature.

On most wards, medicines, including controlled drugs (CDs) were stored safely in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys were generally secured to the walls when not in use, however two trolleys were not secured on the hyper acute stroke ward (HASU). However, when this was reported, staff acted immediately to resolve it.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff gave examples including falls, pressure ulcers, medication errors. Staff received training from the falls team after a patient fall in a 'Baywatch' area.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they were encouraged to report incidents and near misses.

Managers shared learning with their staff about never events that happened elsewhere in the hospital and trust. There had been one never event in endoscopy involving two patients with similar names. Staff were aware and had implemented a new checking process to avoid patients with similar names being placed on the same list.

Staff reported serious incidents clearly and in line with trust policy. Staff at all levels understood the trust processes for investigating incidents.

The trust local incident review panel (LIRP) comprised nurse, doctor, risk and policy representatives. They reviewed incidents that were moderate harm (or above) to investigate and determine whether they met serious incident (SI) thresholds.

The panel referred serious incidents (SI) to the trust post event action review and learning (PEARL) panel. A cardiac arrest panel comprised a critical care consultant, a representative from the patient safety team. They would specifically review cardiac arrests. Both panels identified immediate post event learnings and shared them with staff.

Leaders discussed incidents at the monthly service line meeting which fed into the Clinical Quality Operational Board (CQOB).

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from their managers about the incidents they reported. Service line leaders monitored incident investigation completion. However, most had outstanding investigations that had exceeded trust deadlines. We reviewed minutes of the clinical governance meetings and service line meetings from the previous three months and found they included detailed information, learning and actions to improve and mitigate risks.

Staff met to discuss the feedback and look at improvements to patient care. Managers received automatic alerts of incidents reported daily. Matrons told us they met every morning to discuss incidents reported in the last 24-hours to identify and share immediate learnings. Ward managers told us they shared learnings with nurses and health care assistants at the daily morning safety brief. Staff attended 'Share and Learn' sessions which were interactive and encouraged ownership. Sessions were recorded so that staff who could not attend received the information.

Medical care (including older people's care)

There was evidence that changes had been made as a result of feedback. The service had received feedback that patients were not always able to use the technology that was available to them to make video calls to family during a period of restricted visiting due to COVID-19. In response, the service introduced a calling regime where staff supported patients with twice-weekly calls on a rotational basis.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The service focused their incident investigations on improving healthcare systems, they did not determine or apportion blame. We reviewed 3 serious incident investigation reports and found they identified areas of good practice, care delivery and service delivery problems, and root causes. They incorporated questions from families into the investigation terms of reference and answered them clearly and compassionately in the reports.

Managers debriefed and supported staff after any serious incident. Staff told us that they received support and refresher training from Matrons and the falls team following a patient fall in a cohort bay.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff used a patient clinical pathway record and an electronic care record to plan, give and evaluate care and treatment. Documentation referenced National Institute for Health and Care Excellence (NICE) guidance. For example, the Nutrition Screening (MUST) clinical guideline referenced NICE (2006) 'Nutrition Support in Adults: oral nutrition support, enteral tube feeding and parenteral nutrition' and NICE Quality Standard 24- Nutrition Support in Adults (2012).

Staff told us guidance was easy to access, comprehensive and clear to follow.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff which ensured patients received care and treatment based on national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff understood their responsibilities under the mental health act code of practice.

Staff in acute medicine had attended a training day to help them gain further understanding of how to support patients detained under the mental health act.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a comprehensive board round where this was discussed and staff reviewed psychological and spiritual wellbeing assessments and care plans within the inpatient admission care pathway.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered three meals a day and staff completed two additional ward rounds offering snacks such as biscuits or cake. Staff supported patients to eat and drink if needed and provided fresh water.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. At our last inspection we told the service it should consider a process to assess, monitor and record patient's safety regarding nutrition. At this inspection we found that the service had introduced the malnutrition universal screening tool (MUST) to identify adults who were malnourished or at risk of malnutrition.

Staff recorded MUST risk assessments on the electronic patient record and reviewed the assessment every seven days or on transfer to another ward. We reviewed patient records and found the assessments completed and care plans correct for most patients. However, 3 patient records reviewed had an outstanding MUST risk assessment. We brought this to the attention of the ward manager who took immediate action.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Patients received individualised nutrition and hydration care plans and staff kept records complete and up to date with dietitian reviews if needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff gave us examples of supporting patients with specific dietary requirements.

Staff completed patients' fluid and nutrition charts where needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately.

Patients were generally positive about the quality and variety of food provided.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff recorded pain scores in the patient record.

Staff used pictorial aids to assess the pain of patient who could not communicate verbally. For example, the visual analogue scale (VAS).

Staff prescribed, administered and recorded pain relief accurately. The trust had recently introduced drug charts to the electronic patient record. Staff told us this made it easy to identify when medication was due. Ward managers told us they were able to monitor that medication was being given in a timely way and follow up any missed medication with staff if needed.

Patients received pain relief soon after requesting it. Patients told us that their pain was well managed, and staff responded promptly if they needed pain relief.

The service completed pain audits which assessed how effectively staff had managed patient's pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The Care of the Elderly service participated in the National Parkinson Audit. The objective of the audit is to ascertain if the assessment and management of patients with an established diagnosis of Parkinson's complies with national guidelines including the Parkinson's NICE guideline and NICE Quality Standards.

Cardiology participated in the National Institute for Cardiovascular Outcomes Research (NICOR) National Cardiac Audit. NICOR is responsible for several national clinical audits designed to improve the quality of care and outcomes of patients with heart disease.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The Respiratory service participated in the NACAP audit (national asthma and chronic obstructive pulmonary disease audit) which measures performance against best practice. In June 2022 the service achieved 75% of patient review by a member of the respiratory team within 24 hours of admission and 96% of patients received a discharge bundle before discharge (a series of high impact actions to ensure the best outcomes for patients).

Stroke services Hyper-Acute Stroke Unit (HASU) participated in the national Sentinel Stroke National Audit Programme (SSNAP) which measures both the processes of care provided to stroke patients, as well as the structure of stroke services against evidence based standards, including the 2016 National Clinical Guideline for Stroke.

The service achieved a reduced compliance score of C from January 2022 to March 2022 compared to a score of B from October 2021 to December 2021. This was due to delays in patients being admitted to the stroke ward, being cared for on the stroke ward as well as delays in receiving therapies such as occupational therapy, physiotherapy and speech and language (SALT) therapy. Despite this the service was performing well in many of the domains and were above national average.

Rheumatology participated in the National Early Inflammatory Arthritis Audit (NEIAA). The annual review rate was 100% in Bedfordshire Hospital Trust against the regional average of 47% in East of England (33%-66% range from all regions).

Medical care (including older people's care)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. For example, stroke services undertook a local audit to look at statin use in stroke prevention. This showed that the correct statin and correct dose were prescribed 100% of the time. The service introduced lipid profile passports to help remind patients and GPs of the need for a 3-monthly check.

Diabetes participated in the National Diabetes Inpatient Audit (NaDIA) Harms. They were fully compliant in relation to participation and had robust plans already in place with the stroke service to identify diabetic patients and facilitate rapid referral especially for those on enteral (tube) feed.

Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical audits to provide assurance about local practice in their areas.

The service monitored readmission rates for each service line and reported performance in service line performance packs.

Managers shared and made sure staff understood information from the audits.

Improvement is checked and monitored. They shared audit outcomes with staff at monthly service line meetings and clinical governance meetings.

The endoscopy service was accredited by Joint Advisory Group on GI Endoscopy (JAG). Accreditation is awarded to endoscopy services who have been assessed and have demonstrated that they meet the JAG quality standards, ensuring that they continually improve the quality and safety of the care provided, maintain a strong focus on ensuring patients have a positive experience, provide excellent training and development opportunities for all staff and uphold a safe and comfortable environment for patients and staff.

Clinical audit was being undertaken and there was good participation in national and local audits. The trust performed in line with national clinical audits and had not been identified as an outlier in any of the national audits in the last year.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service average appraisal rate for June 2022 was 82%. Staff told us that appraisals were helpful and allowed them to discuss performance and agree personal development plans. The service had an action plan to increase performance to 90% by the end of the year.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The trust had an ACE (achieving care excellence) preceptorship programme and 15 step challenge available to nursing staff.

Medical care (including older people's care)

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors, including weekly employed doctors and locums told us that they received and appreciated supervision.

The clinical educators supported the learning and development needs of staff. Staff on the respiratory ward told us the practice development nurse had supported them to achieve non-invasive ventilation (NIV) competencies. The service had received support to recruit four additional practice development nurses (PDN).

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff attended daily safety briefs where managers shared patient handover, operational updates, incident and complaints.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Clinical managers told us that they had benefitted from working across a range of service lines and had been supported to take on additional responsibilities. Health care staff told us they were supported to develop new skills.

Nursing and therapy staff working in stroke services received competency and on-the-job practical training. Doctors had access to monthly consultant led training. Managers identified poor staff performance promptly and supported staff to improve. The trust had policies to support manager to deal with performance issues.

Care of the elderly service had developed at team of advanced practitioners to support with the assessment and ongoing care of elderly patients referred into the service.

The endoscopy service was consultant-led, however staff had access to training opportunities as the service planned to introduce nurse endoscopist in line with the model at Bedford Hospital.

Managers recruited, trained and supported volunteers to support patients in the service.

Managers monitored registrations and revalidations for nursing and medical staff. The service provided information following our inspection to show that all medical staff were up-to-date with their revalidation and all nurses were appropriately registered with the Nursing and Midwifery Council (NMC). The trust had a robust process in place to manage staff not meeting the relevant requirements.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients' treatment and to ensure they are receiving the correct treatment and care. There were daily multidisciplinary board rounds where doctors, nurses and allied health professionals discussed patient care.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison team was available for advice and to support ward staff care for patients with mental health needs. Staff told us that they felt very well supported.

Medical care (including older people's care)

Patients had their care pathway reviewed by relevant consultants. Care of the elderly ran a same day emergency care (SDEC) where patients attended for rapid access to diagnostics and assessment. For frail and complex patients this included a comprehensive geriatric assessment (CGA) and for example, lying, standing blood pressure, bladder scan, and cognitive/mood screen (MOCA/GDS) as well as bloods and imaging as appropriate. The trust had a medical outlier team who reviewed medical patients on other wards.

The service also offered a virtual community MDT where any member of the community / primary care team can request a same day / next day MDT via Teams.

The Hyperacute Stroke Unit (HASU) was the regional centre for stroke medicine and was part of the integrated stroke delivery network (ISDN). The service operated 24/7 and accepted patients requiring thrombolysis following a stroke from all neighbouring NHS trusts. The service had recently signed up to the regional telemedicine network for thrombolysis.

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team. These discussions were also evident in the patient notes we reviewed. All the notes we reviewed contained details of multidisciplinary working also involving the discharge and community teams. Further, staff gave us examples of good collaboration between other medical wards, urgent and emergency care. pharmacy and the discharge team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff told us that requests for agency mental health nurses for inpatients with mental health issues were always supported by management.

Consultants led daily ward rounds on all wards, including weekends. The service had consultants working seven days a week providing 24 hours a day, seven days a week cover. A designated stroke consultant was also available.

The service always had senior nurses on site and staff had access to an on-call general manager and senior nurse at weekends.

The service had access to the infection, prevention and control (IPC) team, safeguarding team and pharmacy team for advice seven days a week.

There was discharge officer support seven days a week.

Allied health professionals which included physiotherapists, occupational therapists (OT), speech and language therapists (SALT) were available, however staff shortages were impacting availability and performance in some services, for example stroke services.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle. For example, we saw leaflets about controlling diabetes, living with dementia and preventing falls.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff completed a 'Making Every Contact Count' assessment with patients on admission. They asked patients about alcohol, smoking, eating well, physical activity and mental wellbeing and signposted patients to support if required, for example to community stop smoking services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. During the inspection staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

The service used agency mental health nurses to provide support for inpatients. Staff told us that managers always supported requests for agency mental health nurses.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Act 1989 and 2004 and they knew who to contact for advice. Staff implemented Mental Capacity Act assessments and Deprivation of Liberty Safeguards in line with approved documentation.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. We observed a mental capacity assessment and DoLS application, this was correct and complete.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received and kept up to date with training on The Mental Capacity Act 2005 (MCA), DoLS and consent. Nursing staff compliance was 86% and medical staff compliance was 75%.

Medical care (including older people's care)

Managers told us they had arranged for MCA and consent training to be delivered by an external provider; this was due to commence in September 2022.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spoke with patients who all told us that they had been treated with dignity and respect.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs. Managers told us how staff had worked with partner colleagues in a mental health hospital to provide care in the best setting for patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service treated patients from a wide demographic and staff understood, and respected patients' needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us how they had adapted to visiting restrictions during COVID-19 to make sure patients were able to access their families for support.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with patients who told us they understood their care and treatment plans.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care. We spoke with patients who told us they had been involved in decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service collected patient feedback though the 'Friends and Family Test' which is a short anonymous questionnaire which asks patients to rate their overall experience from very good to very poor. Patients were able to give feedback via their smartphone at the time of their appointment or before discharge, or after discharge using an online survey. Paper postcards were also available.

Patients gave positive feedback about the service. The service performed well in the 'Friends and Family Test' with most wards and services consistently scoring above 90% and in some cases 100%. This meant that most patients who completed the survey rated their experience as very good or good.

The endoscopy service asked patients to complete a patient experience survey and collected feedback from 968 patients from October 2021 to March 2022, this equated to 21% of all patients treated. A total of 98% of patients rated their experience as very good or good. The service planned to introduce a more detailed survey in line with JAG standards to gain a better understanding of where the service could be improved.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The hyper-acute stroke unit was the regional stroke unit. They provided 24 hour, 7 days a week consultant-led care and accepted referrals from other hospitals for patients who required urgent thrombolysis following a stroke.

Medical care (including older people's care)

Facilities and premises were appropriate for the services being delivered. However, St Mary's day unit did not have enough space or a waiting area for patients. The trust planned to relocate this service to a larger area in October 2022.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

Managers monitored and took action to minimise missed appointments. Staff in diabetes introduced a pre-appointment phone call to reduce patient DNA (did not attend).

The service had systems to help care for patients in need of additional support or specialist intervention. Care of the elderly staff provided a same day emergency care service (SDEC) where patients attended rapid access to diagnostic services and medical assessments. For frail and complex patients this included a comprehensive geriatric assessment (CGA) and for example, lying, standing blood pressure, bladder scan, and cognitive/mood screen as well as bloods and imaging as appropriate.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. The service had a dementia nurse specialist and wards displayed dementia awareness boards.

Wards were designed to meet the needs of patients living with dementia. Medical wards had achieved the dementia friendly status. Staff had access to communication aids to help patients become partners in their care and treatment.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. 'This is me' is a support tool to enable person-centred care. It can be used to record details about a person who cannot easily share information about themselves. This helped staff learn about a patient's habits, background, likes and dislikes. We observed 'This is me' posters in use by the bedside.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff assessed communication needs as part of the admission process and recorded this on the electronic patient record.

The service had information leaflets available in languages spoken by the patients and local community. Welcome notice boards containing patient information were in different languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to telephone interpreter services.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could generally access the service when they needed it and received the right care promptly. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Medical care (including older people's care)

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The service had a dedicated outreach team comprised of a consultant and 2 junior doctors who reviewed medical patients on non-medical wards. This meant that medical patients were reviewed by the appropriate specialist within 24 hours of admission, regardless of ward.

The service moved patients only when there was a clear medical reason or in their best interest. The service was forced to use escalation areas when patient demand exceeded the regular bed base, however they repatriated patients to the appropriate ward as soon as possible.

Managers continually reviewed bed configuration to meet patient demand and anticipated pressures such as increases in demand for non-invasive respiratory beds over winter. They allocated experienced staff to escalation areas to keep patients safe.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service had dedicated discharge planners who worked with service line staff and community care providers to ensure safe discharge. Care of the elderly service introduced a new discharge checklist as a potential tool to improve inpatient care.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. The service looked at patients with long lengths of stay to highlight opportunities to discharge patients earlier. Patient length of stay was discussed at service line meetings and presented in performance packs.

Staff supported patients when they were referred or transferred between services. Care of the elderly service introduced 'the silver phone' pathway to speed up and improve the care that frail and elderly patients received. This was done in collaboration with the local NHS ambulance trust. It involved a baton phone held by a senior frailty specialist to provide advice and guidance and to direct patients to the most appropriate care setting. Where possible to allocate an urgent review in same day emergency care (SDEC) to avoid acute hospital admission and to provide community colleagues with support in decision making and shared risk taking.

Rheumatology service introduced a fast track pathway for Giant Cell Arteritis (a type of inflammation of the blood vessels) to help patients get specialist treatment as soon as possible and reduce the risk of complications such as permanent loss of vision, stroke and other complications.

Rheumatology and haematology services were in the process of introducing 'patient initiated follow up' appointments (PIFU) to release outpatient capacity so new patients could be seen sooner.

Managers monitored waiting times and made sure patients could access services and emergency services when needed. However, not all patients received treatment within agreed timeframes and national targets. For example, in July 2022 71% of respiratory patients listed for treatment received it within 18 weeks and the service had a backlog of 398 patients to achieve the 92% referral to treatment target (RTT). Cardiology had a higher backlog, 57% of patients were treated within 18 weeks and the service had a backlog of 1052 patients. Transient ischaemic attack (TIA) or "mini stroke" and stroke data for July 2022 showed 43 patients on the waiting list with an average wait of 6.4 weeks, no patients waited over 18 weeks.

Service line leaders discussed backlogs, waiting times and capacity challenges and performance at monthly service line meetings.

Endoscopy managers tried to keep the number of cancelled treatments to a minimum by providing clear pre-procedure patient information. However, the lack of pre-assessment resulted in higher cancellation rates. Managers told us pre-assessment would be introduced to improve patient experience.

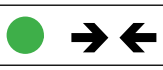
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Themes included poor communication of discharge plans and restricted visiting during COVID-19.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. For example, staff had introduced ward rounds where snacks and high calorie drinks between meals were offered to patients. The service used an incident reporting system that automatically provided feedback to the person who reported the incident.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. The trust had moved away from a directorate to a service line model following the merger of Luton and Dunstable Hospital and Bedford Hospital in 2020. Each service line, for example stroke, care of the elderly or respiratory, had a clinical director, a head of nursing and a general manager who set the strategy, direction and priorities for the service line.

Service leads reported into the general manager and worked with clinical directors and matrons to provide day to day operational leadership to their service line. Each service line was supported by business partners, for example human resources, finance, quality, governance and information.

Wards were managed by ward managers who were supported by matrons who reported into the head of nursing and chief nurse.

Managers understood and managed the priorities and issues the service faced. Managers told us that they faced an increasing patient demand with an exhausted workforce and high staff vacancies.

Managers had identified gaps in nursing and medical staffing and were looking at ways to retain and increase staffing. They had focused on international recruitment and had been successful in supporting international recruits to practice in the UK.

Managers were visible and approachable in the service for patients and staff. Staff told us that service line managers, general managers, ward managers and matrons frequently visited the wards and were aware of the challenges staff faced. Managers told us that being present on the wards for staff and building personal relationships was important to them. Managers told us that they had been deployed to other areas during COVID-19 and this had helped them to develop their leadership skills.

The trust supported staff to develop their skills and take on more senior roles. Staff at all levels told us they felt supported with training and development opportunities, for example HCAs told us they were given time to develop additional competencies. Managers were supported to complete leadership training which included in-house development modules, NHS England quality service, improvement and design (QSIR) training as well as externally accredited qualifications such as MSc in Healthcare management and Chartered Management Institute (CMI) level 5 leadership.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a strategy which was to fully integrate both sites following the merger of Bedford Hospital and Luton and Dunstable University Hospital on 1 April 2020. Leaders told us they had been empowered to develop strategic plans for their own service lines. These would be pulled into one strategy by the integration team when finalised.

The trust was focused on sustainability of services and aligned to local plans within the wider health economy. Their strategy was to continue as a strong partner in the Integrated Care System (ICS) to improve health outcomes across Bedfordshire.

The digital strategy was to merge clinical systems and move to increasingly electronic records.

The trust had values including Teamwork, Honesty, Respect, Inclusivity and Valuing People, (which leads to) Excellence. Staff were aware of the values and told us these had been developed through staff engagement. The values were displayed in staff and patient areas across the hospital. Leaders used tools to help them recognise positive behaviours and have conversations with staff when they observed behaviours not in line with trust values.

Leaders and staff understood and knew how to monitor progress and shared performance reports at monthly service line meetings and to the board of executives.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Medical care (including older people's care)

Staff at all levels felt respected, supported and valued. Staff told us they were proud to work for the trust. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

General managers and directors of nursing told us they were trusted by chief executives to manage their areas; they described the culture as empowering with support.

Staff at all levels were focused on the needs of patients receiving care. Staff told us they were short staffed but could always rely on colleagues to help.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff completed equality, diversity and human rights training; compliance for medical staff was 81% and nursing staff 92%.

The service had an open culture where patients, their families and staff could raise concerns without fear. We reviewed complaint investigations which included families' concerns.

Staff in most areas told us they felt very supported and told us staff morale was good. Junior doctors appreciated the support of clinical directors and ward staff told us they were supported by ward managers and matrons.

Staff told us that the head of nursing and deputy head of nursing for medicine were visible and approachable for the ward teams.

Service line leaders including general managers, clinical directors told us they felt supported and trusted and described the board as having an 'open door' culture.

Leaders understood morale was lower than they wanted. They recognised that staff in some areas of the service had been under extreme pressure, for example wards which had been designated as COVID-19 wards. They were determined to acknowledge staff commitment and particularly support staff in these areas. Matrons presented patient care 'Daisy Awards' to staff who received patient compliments. We observed this celebrated in service line meeting minutes.

The trust arranged for webinars and seminars, including 'event in a tent' to support staff wellbeing but acknowledge that staff were exhausted and becoming less resilient.

The trust had Freedom to Speak Up Guardians, however, some staff we spoke with did not know who they were, although they recognised the role and its importance. Managers told us the trust was promoting the service.

Managers told us the trust had invested in improving the environment in staff areas, within the limitations of the age of the building.

Staff had been trained to be peer listeners as part of the trust listening service, information was available to staff on the trust intranet and advertised in the weekly newsletter.

Managers were extremely proud of the team. They told us "staff work so hard to put patients first, always with a smile" and "everyone goes above and beyond to get the job done." Staff at all levels told us how friendly the organisation was, several staff said, "it's the friendliest organisation I've worked in".

Managers were excited about the integration and passionate about taking the strengths from both hospitals, while recognising the differences, to deliver the best services for patients.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

The service line triumvirate met on a weekly basis to review service-related issues and agree any immediate actions to address quality and safety. Service line leads had daily huddles and monthly performance review with the care group triumvirate and presented at the care group quality assurance group.

Wards had quality review meetings through the corporate nursing structure. They had decision making powers in accordance with the trust scheme of delegation and attended cross-cutting boards to ensure that there is oversight across service lines to achieve key objectives.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The service line triumvirate and key staff attended monthly service line meetings to discuss operational issues, staffing, capacity and risk.

Service line leaders produced performance reports and presented these to the executive meeting, which later fed into the trust board. They discussed referrals, 18-week referral to treatment, outpatient attendance including DNA (did not attend), booking backlogs, length of stay, readmission rates, incidents, risk register, staffing, vacancies, absence and turnover.

Leaders attended monthly clinical governance meetings where they discussed complaints, compliments, FFT, incidents, near misses, clinical audits, quality improvement projects, mortality reviews, training and appraisal compliance. This information fed into the trust clinical quality outcome board (CQOB) and into the overarching emergency medicine board.

The trust mortality review process was aligned with local policy and national guidance (NHS England Learning from Deaths (LfD) framework). Service line leaders used findings from a structured judgement review process (SJR) to inform constructive, clinical debate and review of practice and identify and share themes to support learning across service lines, trust and partner organisations. From November 2021 all nosocomial (hospital acquired) deaths automatically triggered an SJR.

An extensive set of policies was readily available on the intranet and was supported by standard operating procedures and processes, these were managed by the trust policy advisory group.

We reviewed meeting minutes and saw that conversations that had taken place and the decisions made were clearly detailed. Actions could be tracked, and minutes showed they had been completed.

Meetings were well attended by individuals with the appropriate level of seniority for decisions to be made. Standard agendas were used, which ensured discussion of clinical incidents and patient experience, as well as assurance reports from specialities within the care group.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams used systems to manage performance effectively. Service line leaders used dashboards and performance packs to monitor performance. They presented quality, workforce and financial performance information to the executive team on a risk based frequency, ranging from monthly to annually.

They identified and escalated relevant risks and issues and identified actions to reduce their impact. Each service line had a risk register and service line leaders reviewed risks at monthly meetings, as well as after an incident. The trust risk committee validated risk ratings.

They had plans to cope with unexpected events. Staff had access to a business continuity plan which was available on the trust intranet. Ward staff had access to a business continuity laptop and paper back up plan to use if the IT system failed.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. For example, leaders in the care of the elderly service line had proposed and gained funding for new staffing models including advanced practitioners to improve patient care and experience.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required. The information systems were secure but not completely integrated.

The service collected and managed information well, using electronic systems with security safeguards

Information systems were secure. Staff could find the data they needed, in easily accessible formats.

Managers used financial reports and performance dashboards to make decisions and improvements. We reviewed meeting minutes and service line presentations where quality, workforce and financial information had been used to monitor and improve performance.

Staff had access to information through desktop computers and handheld tablets. They attended training before the launch of new systems.

Data or notifications were consistently submitted to external organisations as required. The service participated in national reporting and collated and submitted information to national audits.

Information systems were not all completely integrated; however, the trust had a digital strategy which aimed to align the different information systems.

Medical care (including older people's care)

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

There were effective systems to engage with staff including an annual staff survey which asked staff for feedback on their job, team and managers, as well as health, wellbeing and safety at work and personal development.

Most staff told us they felt informed and up to date with what was happening within the wider trust. Information was shared through different forums such as team meetings, newsletters and verbally. Staff were invited to attend engagement events such as 'event in a tent'.

Leaders collaborated with partner organisations to help improve services for patients. The trust was a strong partner in the Integrated Care System ICS and the Bedfordshire Care Alliance. Priorities included reducing health inequalities through tailored, easy access, integrated health and care services across Bedfordshire to improve population health outcomes.

The care of the elderly service introduced a new pathway to speed up and improve the care that frail and elderly patients receive. This was known as the 'silver frailty phone' and was a collaboration between the hospital and the local NHS ambulance trust.

The service collaborated with a mental health NHS trust, community care providers, primary care and the local authority when they developed 'virtual ward' which allowed patients to get the care they need at home safely and conveniently, rather than being in hospital.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services.

The care of the elderly service took part in a case study to prevent impatient falls by implementing an 'avoiding falls level of observation assessment tool' (AFLOAT).

Nursing staff from neurology collaborated with a mental health NHS trust to improve integrated working and make it easier for patients who used both services.

The service introduced several innovative services to prevent patients from unnecessary hospital admission, for example same day emergency care unit (SDEC), emergency department in-reach teams, the 'silver frailty phone', virtual community multidisciplinary team (MDT) and virtual ward. These services helped staff provide care to people quickly and efficiently.

They had a good understanding of quality improvement methods and the skills to use them. Managers used quality assurance tools based on the PDSA model (plan, do, study and act) to measure and improve quality. They used the tools to audit compliance against new Medicines and Healthcare Products Regulatory Agency (MHRA) and National Institute for Health and Care Excellence (NICE) guidelines. They shared learnings and made improvements where needed.

Leaders encouraged innovation and participation in research. For example, the stroke service was introducing telemedicine artificial intelligence.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and had plans in place to ensure everyone completed it.

Most nursing and midwifery staff received and kept up to date with their mandatory training. Mandatory training data provided by the trust showed an overall completion rate of 78.43% for core statutory and mandatory training compliance in July 2022 and an 80.98% completion rate for advanced statutory mandatory training in July 2022 against the trust's target of 90%. Mandatory training was a combination of online training modules and face-to-face training sessions. We were told the service had been working with the training team and training packs were sent out to staff in July 2022, these are due to be collected and uploaded onto the electronic staff records.

Data reviewed after the inspection demonstrated the training and learning team had created a mandatory training action plan which included a trajectory to increase compliance over the next 18 months.

Medical staff received and kept up to date with their mandatory training. Mandatory training data provided by the trust showed an overall completion rate of 89.67% for core statutory and mandatory training compliance in July 2022 and an 86.70% completion rate for advanced statutory mandatory training in July 2022 against the trust's target of 90%.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training comprised of core statutory training for all staff and advanced statutory training for relevant staff.

The service also held monthly Practical Obstetric Multi-Professional Training (PROMPT). This was evidence-based training for obstetric emergencies and aided improvement in outcomes for mothers and babies. The overall compliance for staff completion of this training for all staff groups was at 91% total midwife attendance and 95% for obstetricians (trainees) which had met the trust's target completion rate.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Data reviewed after the inspection demonstrated nursing and midwifery staff had an 86.15% compliance in tier one dementia training and a 50% compliance rate at tier two dementia training, against a trust target of 90%. The medical staff had a 90.57% completion rate at tier one. Training compliance on the mental capacity act and consent was at 77.27%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training compliance was monitored by managers, staff were prompted to book training before it expired. Managers we spoke with confirmed that there were delays in training completion, due to the challenges in releasing staff and they were working with the training team to find solutions.

Staff told us they had booked bank shifts in addition to their regular shifts in order to attend training days.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse.

The service provided training for nursing and midwifery staff specific to their role on how to recognise and report abuse. Training data demonstrated that staff were required to complete safeguarding training for adults and for children, however, not all staff had completed training to the required levels.

Nursing and Midwifery staff had a 91.83% completion rate for safeguarding children at level 2 and a 56.86% completion rate at level 3, against a trust target of 90%. The level 3 training completion demonstrated poor compliance with the royal college of nursing (RCN) intercollegiate guidance. Review of information received after the inspection indicated that an action plan was in place to address the safeguarding level three training for children. The service intended to work with the safeguarding team to plan a bespoke training session for the maternity team, the action plan indicated this was in progress.

Nursing and midwifery staff had a 79.54% completion rate for adult safeguarding at level 2 and a 75% completion rate at level 3, against a trust target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff had a 91.08% completion rate for safeguarding children at level 2 and an 88.89% completion rate at level 3 specialist, against a trust target of 90%.

Medical staff had a 93.96% completion rate for adult safeguarding at level 2 and a 75.74% completion rate at level 3, against a trust target of 90%.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with understood how to identify any concerns about harassment and discrimination and were able to describe the process of escalation. Equality, diversity and human rights is part of the core mandatory training programme.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff completed training in safeguarding and knew how to apply this in practice. Staff could access support from the safeguarding lead if they had concerns. We heard examples at the handover meetings of safeguarding concerns, action taken or to be taken and agencies involved.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding policies in place for both adults and children. Maternity services had additional policies in place for female genital mutilation (FGM).

Staff followed the baby abduction policy and undertook baby abduction drills. The policy set out staff roles and responsibilities during the lockdown of the maternity department. The trust had conducted a baby abduction drill in June 2022. The babies were placed in alarmed cots that alerted to unauthorised removal from the cot.

The service had close circuit television (CCTV) monitoring in place and entry to the wards and delivery suite was restricted. In order to gain access to the maternity wards or delivery suite there was a secure buzzer system in place.

Staff checked identification and the reason for entry prior to admittance. Staff were aware it was possible to gain entry by following another person and on the maternity wards we observed staff checking the identity of visitors on admission, however, we did not always observe a robust process on the delivery suite. We did observe signs asking all visitors to use the buzzer system to gain access and not to hold doors open for anyone else. In order to exit the wards staff had to release the door, we observed this was strictly adhered to whilst on inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The areas we visited on inspection were visibly clean, with furnishing such as patient chairs that were suitable for cleaning. We observed cleaning of the birthing pool in the delivery suite after use.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service had a monthly cleaning score sheet assessment. Our review of the data received after inspection demonstrated that staff were using the monthly cleaning score sheets effectively to maintain standards of cleanliness. All staff were aware of their responsibility to maintain cleanliness. The cleaning score sheet indicated the areas of responsibility between, cleaning staff, estates staff and nursing staff. This gave the service the opportunity to identify areas of non-compliance and to monitor improvements to practice.

Infection control was clearly recorded on the ward quality and safety information board, with areas for improvement, audit results and areas of good practice. The Ward 32 information board indicated one of the ward domestics had been awarded a certificate for the high quality of cleaning in the clinical area.

The service generally performed well for cleanliness. The service had a comprehensive infection prevention and control audit tool. The audit tool red, amber, green (RAG) rated the scores to demonstrate if an area was compliant. Review of the May 2022 audit of ward 33 (postnatal) indicated the patient bay scored 95%, equipment 100% and clean utility 100%, however the midwives' station/ doctors' office only scored 40%. Review of the June 2022 audit of ward 32 (antenatal) indicated the patient bay scored 94%, equipment 100% and clean utility 83%, the midwives' station/doctors' office scored 60%.

The audits gave the service the opportunity to identify areas of non-compliance and to monitor improvements to practice.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff in all clinical areas we visited wore PPE appropriately while delivering care to women and disposed of the PPE correctly after use.

The trust had issued guidance to staff on wearing of surgical masks around the site. The guidance had been emailed to all staff, however, there was inconsistency over the interpretation of the guidance, on when a mask should be worn. This was escalated at the time of inspection to the local leaders and actioned.

We observed staff decontaminating their hands before and after patient care. All staff wore uniforms with short sleeves to remain bare below the elbows for effective hand hygiene. All clinical areas had hand washing sinks and hand gel dispensers in staff and patient areas.

Maternity

Clinical areas consistently monitored hand hygiene practices. We reviewed the hand hygiene audits for maternity inpatient audits from May to July 2022, which showed these were conducted consistently every month in all clinical areas. Ward 33, postnatal, consistently scored over 91% and had achieved 100% in May 2022. This meant that the service had the opportunity to identify issues with hand hygiene and improve hand hygiene practices.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff clean clinical equipment and observed staff had labelled equipment that was not in regular use with 'I am clean' stickers which were dated.

Environment and equipment

The maintenance of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

The design of the environment did not always meet the needs of the service. The maternity service was challenged by the design and layout of the building infrastructure, for example, if a mother had to be transferred to the intensive care unit, she would have to be wheeled along an outdoor undercover walkway into the main hospital building.

The internal environment of the maternity department had been maintained, however, the lifts women and visitors used to access the maternity wards were on the maternity risk register due to reliability issues.

The trust had plans for a new acute services block and a new ward block which would include maternity services. This is planned to be completed in 2024. The replacement facilities would improve the women's experience but would also create additional capacity in response to growing demands for the service.

The lobby area to the postnatal ward (Ward 33) had 4 patient beds blocking it. The ward manager explained they were waiting for the porters to collect them. The access to the ward managers office and to the waste storage area were severely restricted and posed a fire risk. This was escalated at the time of inspection and the beds were removed.

We observed that fire doors to the waste storage areas and in the postnatal ward were propped open. This was escalated at the time of inspection and were closed immediately. The trust recognised that due to the hot weather the fire doors had been propped open.

Staff did not always dispose of clinical waste safely. Wards 32 and 33 (postnatal and antenatal) had a waste storage room in the lobby area outside of the ward, which was accessible to the general public. These storage areas had double doors, which were fire doors. On inspection the doors to this area on Ward 33 were propped open and the rubbish disposal room was untidy and full of both clinical waste bags, household waste bags and sharps bins. It was not possible to close the inner door due to the amount of rubbish. The sharps bins had been closed correctly but not signed and dated. This was escalated at the time of inspection to the ward manager and the outer fire door was closed. At the end of the inspection we returned to these storage rooms on both wards, the waste had been removed, however, the fire doors were still propped open. The trust was actively addressing these concerns.

We observed that staff disposed of clinical waste including needles and domestic waste correctly. Staff ensured that all waste receptacles including sharps bins were not overfilled. A review of 5 sharps bins on the wards indicated all were clean, dated and not overfilled, however, 4 of the 5 did not have the temporary closure in place.

Women could reach call bells and staff responded quickly when called. Women we spoke with told us that staff responded promptly if they called for assistance.

Staff carried out daily safety checks of specialist equipment. Emergency clinical equipment such as resuscitation, oxygen, resuscitaires and suction equipment was clean, stored appropriately and was available for use at short notice. Resuscitaires are used to support new born babies who may need extra warmth or resuscitation after delivery. The emergency equipment was checked each day to ensure it was in working order. We reviewed the documentation from July to August 2022, this confirmed the daily checks were consistently undertaken.

The emergency trolleys were secured with tamper proof tags. We also checked a random sample of consumable equipment stored in the emergency trolleys, this was found to be in good condition and in date.

We saw that electrical equipment that required a portable appliance test (PAT) had this completed within the specified timeframe. PAT testing is the process of checking electrical appliances for safety through a series of visual inspections and electronic tests.

The service had suitable facilities to meet the needs of women's families. The maternity department has a dedicated drop-off bay in front of the building for the women to be dropped off prior to the car being parked in the car park. The patient rooms and bays had chairs available for families, which were padded, covered in a suitable fabric for cleaning and well maintained.

The service had enough suitable equipment to help them to safely care for women and babies. The service had a range of equipment to monitor women and their babies. Equipment we checked such as blood pressure machines and cardiotocography (CTG) machines were up-to-date with servicing and safety testing. The equipment librarian explained they regularly went to the wards to collect borrowed equipment that was no longer required, return equipment or to take equipment for repair and checking.

We checked a random sample of consumable equipment such as syringes and needles; all were found to be in good condition and in date.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman. Staff took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Midwives completed risk assessments at the pregnancy booking appointment and streamed women to consultant-led care if risks were identified. The service had a system in place for the midwives and clinicians to review the risk assessments during each appointment or care episode. The risk assessment update should be documented on a sticker system, this system was designed to ensure the risk assessment was updated on every visit and was an easy reference tool for all staff to identify high-risk mothers.

A review of 8 sets of women’s notes demonstrated the system was not embedded into the clinicians practice and the doctors preferred to complete risk assessments in the longhand notes. The risk and governance midwife was aware that the stickers were not completed at every contact and have asked the clinicians to design a label they would be happy to use.

We reviewed 8 sets of women’s notes which indicated that carbon monoxide monitoring had not been completed. We were told this had been suspended during the pandemic but had recently re-started. Information received from the service after the inspection indicated that data was not correctly transferring between the two information technology (IT) platforms currently used by the maternity service for data collection. A manual collection of the June and July 2022 data indicated compliance was at 85% for carbon monoxide screening at booking.

The review of the women's notes also indicated that, in cases where English was not the woman's first language, women were not always asked about domestic abuse. Data received after the inspection indicated that an audit of 2,404 women between August 2021 and August 2022, for whom English was not their first language, the compliance rate was at 78% at booking.

Maternity services had a midwife-led day assessment unit. The day unit worked on a booked appointment system and the responsibilities included completing monitoring checks on mothers. The checks included fetal monitoring, mothers with high blood pressure and premature rupture of membranes. The day unit had escalation procedures in place if the mother needed an overnight stay, if there were any concerns about women at risk of deterioration or if it was unsafe for the woman to be seen in the unit.

The day unit had a referral pathway in place if the unit was at capacity or if they were unable to see the woman safely. We observed the unit referring two women to the maternity triage unit for blood tests as they did not have capacity to see the women on the unit.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used Maternity Early Obstetric Warning System (MEOWS) to detect the deterioration during pregnancy, delivery and postnatal. This was evidenced in all the women's notes we reviewed on inspection.

Women's records we reviewed demonstrated that staff completed growth charts at every antenatal appointment in line with guidance. The service had fresh eyes and ear initiative in place for peer review of CTG monitoring. The service had designed a sticker for CTG interpretation which incorporated physiological interpretation, these were attached to the women's records.

The nursery nurses maintain the observation records for the transitional care babies. These are usually pre-term babies who were able to be kept on the ward with their mother. At delivery the baby was red, amber, green (RAG) rated and this determined the frequency of observations, for example a red rating would indicate observations at least every 2 hours for 12 hours. The baby checks included weight on day 3 and a non-invasive transcutaneous bilirubin check. The checks were plotted on a gestational age-appropriate chart.

Staff completed risk assessments for each woman on admission or arrival in the triage unit, using a recognised tool, and reviewed this regularly, including after any incident. The service used the Birmingham Symptom-specific Obstetric Triage System (BSOTS). Managers told us this had made a significant difference to woman. The BSOTS system had standardised the triage of women and resulted in a clear process of prioritising the order in which patients receive clinical attention. The expectation was women would be seen within 15 minutes of arrival and would be categorised from red, need to be seen immediately, through orange and yellow to green, need to be seen within 4 hours.

Audit data from June and July 2022 indicated 90% of women were seen within 15 minutes of arrival and 77% of women had ongoing care within the BSOTS time frame.

Staff completed individual risk assessments on admission to the delivery unit. These included venous thromboembolism (VTE), which we saw staff had completed correctly in the medical records.

The service used the World Health Organisation (WHO); 5 steps to safer surgery checklist for all theatre procedures. We saw that this was recorded in the notes we reviewed and were audited monthly to confirm ongoing compliance. Audits observed showed 100% compliance with the checklist.

Staff knew about and dealt with any specific risk issues. Staff completed regular clinical observations for women in pregnancy and in labour. This enabled staff to detect anomalies, sepsis and individual risks early.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The service had specialist mental health midwifery team available for support and guidance for both the clinical staff and the woman. Staff were able to demonstrate good multidisciplinary working in the management of complex cases.

At any time in pregnancy when a woman identified as having a mental health need, a referral was made to the perinatal mental health midwives who will triage the mental health requirement. The red, amber, green (RAG) rated criteria will determine the care pathway the woman is on, for example, women on the red and amber mental health pathway would see a consultant obstetrician who will continue to risk assess their mental health needs throughout the pregnancy. Out of hours the service could access the hospital mental health team for advice and support.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff would refer the woman to the specialist mental health midwife if they were concerned that a woman had deteriorating mental health. At any time during pregnancy a woman who was assessed as having increasing mental health needs could be escalated from her current mental health pathway to a higher pathway for further monitoring and care planning.

Staff shared key information to keep women safe when handing over their care to others. Staff shared learning and key messages about safety critical incidents or issues within the environment during the handover process and again within safety huddles.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed midwifery and medical handovers, staff provided a comprehensive account of the care provided using the Situation, Background, Assessment and Recommendation (SBAR) model.

The service had a deteriorating patient policy in place and staff were able to tell us the escalation process in the case of a deteriorating woman.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The service had challenges with the recruitment of midwives due to the national shortage in this staff group. Managers told us they had a recruitment plan which included international recruitment, return to practice midwives and increasing the number of student midwives.

On the day of our inspection a staff member from the ward was moved to the delivery unit for the shift due to staff shortages.

Staff reported that they struggled to take breaks especially on night shifts. Staff we spoke with told us they were concerned as they could not provide the care they wanted to, and that something could be missed. Staff also raised concerns that because of the staffing pressures they did not have the time to spend with women to give all the information they required.

A review of staffing meeting acuity data after the inspection indicated that for the 4 weeks from 11 July to 1 August 2022 staffing met acuity only 21% of the time. The service had reviewed the data and the number of midwives not consistently meeting the acuity of the women was in part due to a high number of women with complex care needs.

The local managers were visible, supported staff and would relieve staff for breaks.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service regularly reviewed staffing. Staffing was also reviewed following the Ockenden report. This meant that the service needs were changed, and the service needed to recruit additional full time equivalent midwives.

The service had an in-date version-controlled maternity escalation policy for staffing and capacity. The policy included escalation procedure flow charts which were red, amber, green, black coded. Black would indicate unit closure.

The ward manager could adjust staffing levels daily according to the needs of women. Managers reviewed staffing daily, assessing staffing levels for the day and the week ahead. Staff moved between antenatal and postnatal wards and the delivery unit to meet the needs of the women in each area. The community midwives could also be required to cover in the unit.

The number of midwives and midwifery care assistants did not match the planned numbers. A review of the data received after the inspection demonstrated the service had an establishment full time equivalent (FTE) of 135 midwives in the delivery suite and maternity wards and staff in post of 97.6 FTE. The maternity FTE for outpatients and community midwives was 91.5 and the service had 71.3 FTE in post.

The service had high vacancy rates. A review of data received after the inspection demonstrated the maternity service had a vacancy rate on the delivery suite and maternity wards of 21.31% in June 2022 against a trust target of less than 5%. The service had a midwifery workforce predictor in place for 2023. The workforce predicator was a forecast tool which included outflow for example retirees, and inflow for example, recruitment. The forecast tool was used to assess predicted staff in post in March 2023. The baseline midwifery staff in place as of June 2022 was 252.76 full time equivalents (FTE) the forecast of midwifery staff in post for March 2023 is 299.50 FTE.

The service had a turnover rate of 13.43% delivery suite and maternity ward staff in June 2022 against a trust target of 10 to 12%. Review of the workforce predictor plan indicated the service had plans in place to try to increase staff retention.

The service had high sickness rates in the nursing and midwifery staff on the delivery and maternity wards with a sickness rate of 12.13% in June 2022 against a trust target of less than 3.25. A review of data received after the inspection indicated from December 2021 to June 2022 the sickness absence on the delivery suite and maternity wards was consistently over 9% and from April 2022 to June 2022 was deteriorating.

Managers used bank and agency staff and requested staff familiar with the service. Managers we spoke with told us that they had regular agency staff that were familiar with the service.

Maternity

Managers made sure all bank and agency staff had a full induction and understood the service. The service used regular agency and bank staff and booked shifts in advance. All bank and agency staff had a local induction to the clinical area which was documented. The induction was structured and included passwords to allow access to all the relevant information technology (IT) systems.

The service had an agency midwife pre-employment clinical checklist to assess the previous clinical experience and areas the midwife had previously worked in, for example, delivery suite.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. The service had a skill mix of doctors including junior doctors, middle grades and consultant obstetricians to care for women. The recommended consultant hours were met by the service. Consultants held ward rounds every day supported by junior medical staff. Following the Ockenden review the service had an evening ward round.

Staff on the midwife-led triage unit and midwife-led day unit both told us the unit would be run more effectively if there was a dedicated doctor available. They had to bleep the delivery suite doctors to attend when needed, this could lead to delays if the doctors were attending to women in the delivery suite.

The medical staff matched the planned number. The service had a medical establishment of 37.3 full time equivalent (FTE) medical posts and had 38.7 (FTE) medical staff in post in June 2022.

Sickness rates for medical staff were low. Review of the data after the inspection demonstrated from December 2021 to June 2022 sickness rates were at their highest in February 2022 to March 2022, with a high of 10.48% in the middle grade doctors in March 2022. From April 2022 to June 2022 the rates have consistently fallen to a 0% sickness absence in June 2022 for medical staff.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants completed rounds seven days a week and were supported by a team of speciality registrars and junior doctors. There was always an anaesthetist available for the delivery suite. The critical care outreach team and intensive therapy unit (ITU) provided support when requested.

The service always had a consultant on call during evenings and weekends. The service had a consultant available out of hours, however there was inconsistency over when there was cover from home or with a resident consultant. The junior middle grades cover nights with the consultant at home whilst the experienced specialty doctors cover nights with a resident consultant.

Records

Staff kept records of women's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care, however, they were not always stored securely.

Records were not always stored securely. Women's records were stored in lockable record trolleys. On inspection we observed the record trolleys in all areas, including antenatal clinic and the wards, were often unlocked. We escalated to the ward manager on the postnatal ward on inspection and a return to the ward later in the day indicated the notes trolleys were locked when not in use.

Maternity

Women's notes were completed and all staff could access them easily. We reviewed 8 sets of maternity records, all records included mental health assessments, fetal movements, risk factors such as high BMI, MEOWS, and entries were signed and dated. This meant that information about women accessing care was available to staff. The women had 2 sets of paper records. The women held one set of records and the service the other, this ensured the women always had a copy of their notes available.

The service had different information technology platforms for recording women's data for audit and assessment purposes. The two platforms did not always effectively transfer data between the two systems, which resulted in a lack of accessibility to all data held.

When women transferred to a new team, there were no delays in staff accessing their records. Women had handheld records which they took to all clinical appointments or when accessing care from other services.

Medicines

The service used systems and processes to safely prescribe and administer medicines. They did not always store medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely. The service used electronic medicine administration records for women in hospital. Prescription records we reviewed indicated staff had administered medicines in line with the prescription. The midwives could administer medicines using midwife exemptions in line with the nursing and midwifery council (NMC) guidance.

We observed a midwife pain assessment of a women. The midwife assessed the severity of the pain and checked if any medicines were due. She discussed with the woman the medicine to be administered. All checks were done correctly, and administration was done safely.

Staff reviewed each woman's medicines regularly and provided advice to women about their medicines. Staff completed medicines records accurately and kept them up to date. Our review of patient records demonstrated that staff completed and reviewed each women's medicines regularly. Staff provided support and advice to women about their medicines, for example, women were supported to self-administer and received specialist input when required, such as mental health.

Staff learned from safety alerts and incidents to improve practice. Managers provided information about safety alerts and incidents within maternity services during handovers and safety huddles.

The service conducted controlled medicine audits. A review of the Ward 31 May 2022 audit indicated the audit included comments and responsibility. The audit indicated an 85% compliance. The audit did not find any major areas of non-compliance.

Staff did not always store all medicines safely. Medicines storage temperatures were recorded, however temperature excursions were not always reported to pharmacy as per trust policy. This was demonstrated in a review of the temperature logs between June and July 2022; therefore we could not be assured that medicines were always safe and effective to use. When fridge temperature excursions were reported, pharmacy acted quickly to investigate and resolve the issue. Our interview with senior pharmacy staff confirmed that the pharmacy department were also taking steps to install controlled room temperature storage solutions to ensure safe storage of medicines stored at room temperature.

Maternity

An inspection of the medicine storage areas demonstrated controlled medicines were stored in a double-locked medicine cupboard and a review of the controlled medicine log-books indicated they were up-to-date, without any omissions. The nurse in charge held the medicine cupboard keys.

Women's own controlled medicines were logged in a separate log-book, which was signed and dated, and securely stored.

A random sample of medicines including intravenous fluids were checked. All were in good condition, in date and stored appropriately.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with knew how and what types of incidents to report through the trust's electronic reporting systems.

The risk and governance midwife informed us that the service had plans for a 'hot' Saturday to review any overdue serious incidents or open incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. Our interviews with managers and review of incident data from August 2021 to July 2022 confirmed this.

Managers shared learning with their staff and across the trust. The service shared learning from across the trust in various formats, including posters and newsletters. The service produced a newsletter called 'risky news' for staff which was a snap-shot update on incidents and learning for staff.

Staff reported serious incidents clearly and in line with trust policy. Staff we spoke to were able to give examples of serious incidents and understood the reporting process. A review of the data after the inspection indicated the service had 13 reported serious incidents from August 2021 to July 2022.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Duty of candour was covered in the obstetric mandatory training day. When asked, staff were able to give examples of the practice of duty of candour. Staff had an individual small information card explaining the duty of candour. All staff we spoke to understood the importance of duty of candour and knew how to report an incident, however, not all staff understood their responsibility to be open and honest and thought duty of candour was the responsibility of the senior team. The senior midwife or clinician would take responsibility for duty of candour once the incident had been reported.

A review of the data after the inspection indicated the service had 13 reported serious incidents from August 21 to July 2022. The data demonstrated all 13 incidents had initial duty of candour letters sent.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with confirmed that managers provided feedback about incidents they had reported. Learning was shared via email, individual feedback and a newsletter. Staff could request feedback through the electronic incident reporting system.

Staff met to discuss the feedback and look at improvements to patient care. Managers met weekly to review incidents reported by staff. This process also incorporated a harm level review and assessment against the serious incident framework. A review of the serious incident action plans demonstrated the service shared learning, developed new guidelines for staff and presented at the governance meetings and senior midwives' meetings. Action plans included recommendations, responsibility, updates and deadlines.

The service managers attended the Local Maternity and Neonatal System (LMNS) serious incident meeting which was held monthly and from which an action plan was generated and learning shared more widely.

There was evidence that changes had been made as a result of feedback. The risk and governance midwife informed us guidelines were changed in response to incidents and themes from incidents inform training, for example a sepsis scenario. The service had videoed a woman's experience and used this for training on PROMPT.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Review of the serious incident data from August 2021 to July 2022 demonstrated incidents were investigated, action plans put in place, learning shared and the women were involved.

The risk and governance midwife was the main point of contact for women involved in incidents. They would see the woman soon after the incident, keep in touch with them, ask them for their views and see them again once the report is completed.

Managers debriefed and supported staff after any serious incident. Hot debrief was undertaken when incidents occured and then an action after review meeting. A scoping exercise took place within 72 hours and included all appropriate specialists, for example, anaesthetists.

Staff informed us managers were always supportive after any serious incident.

Is the service effective?

Good

Our rating for effective remained the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service had a comprehensive computer database of policies. The database had a dedicated maternity page and policies could be searched for by name alphabetically or key word. The policies were version-controlled and indicated if they were trust or local policies.

The deputy head of midwifery was able to navigate the computer database easily and was able to demonstrate how to find and access specific policies, however, staff on the delivery suite did not find the computer system easy to navigate. The delivery suite had a paper based copy of the safeguarding policy, which staff referred to, this had a review date of August 2009.

Data reviewed after the inspection indicated there was a current version of the safeguarding policy and this was due for review in June 2022. The policy was version-controlled and referenced associated documents such as information sharing protocol and guidance for women with female genital mutilation.

The electronic maternity policies we reviewed were in date, clearly written and easy to follow. Policies referenced relevant national guidance for example the Management of Venous Thromboembolism during Pregnancy policy references the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines and the National Institute for Health and Care Excellence (NICE) guidelines.

The service had processes in place to monitor and assess women with additional needs for example reduced fetal movements and gestational diabetes.

A review of women's notes indicated the fetal growth was plotted on the fetal growth chart in line with national guidance.

The service had a comprehensive audit programme in place to monitor local standards and compliance, for example, the service audited VTE compliance and provided training and feedback on the results. The February 2021 – June 2022 Results indicated a 100% compliance in 13 of the 17 months. Where there was a drop in compliance this was investigated.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. The service had a dedicated mental health midwife and the support of the hospital mental health team out of hours. Staff were able to tell us how and when they would access these services. Staff completed mental health training as part of the mandatory training programme.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed the handover meetings were comprehensive and addressed all the needs of the women. Women with complex mental health and safeguarding concerns received multi-disciplinary care from a specialist team which had expertise to support these women and linked with other services.

As part of the Local Maternity and Neonatal System the service was part of the development of the local perinatal mental health service. This service was to provide support for women with moderate to severe mental health difficulties as a consequence of their experience of loss and or trauma during their maternity or fertility journey.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The service had a comprehensive menu for the women to choose their meals from, which catered for all tastes and needs. Women told us they appreciated the choice and variety of food available and the food was good.

The antenatal and postnatal wards had hot drinks and snacks available on the ward. Women were able to help themselves to refreshments whenever they required.

The service conducted infant feeding audits. Data reviewed after the inspection indicated that 78.1% of women breast fed in June 2022. The service conducted an audit of mothers' feeding experience in January 2022, a very small data set was used, however, this indicated women did not feel supported in learning about feeding whether breast feeding or bottle feeding. The service had actions in place, which included a quarterly review to look at trends, monthly feedback at the senior midwives meeting, a repeat audit schedule and staff training courses.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Women received pain relief soon after requesting it. Women told us they were offered pain relief regularly throughout the day and staff responded quickly when they made requests for pain relief overnight.

Staff prescribed, administered and recorded pain relief accurately. Medicine records we reviewed demonstrated that pain relief had been prescribed and administered in a timely way on women's request by midwifery staff.

We observed a midwife assess a woman who was in pain after a caesarean section. The midwife discussed the medicines with the woman and asked the woman to inform her if the pain relief was not effective. All checks were done correctly, and administration was done safely.

Women were able to request epidural pain relief during their labour. The service guidelines were that an anaesthetist should attend to insert an epidural within 30 minutes of being informed or within 60 minutes in exceptional circumstances. A review of the audit data after inspection indicated the average time for anaesthetist attendance was 24 minutes, 15% of women waited more than 30 minutes and 3% more than 60 minutes.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.

Outcomes for women were not always positive, consistent and met expectations, such as national standards. A review of the local maternity dashboard from March to June 2022 indicated that the service did not always meet national targets, for example the overall instrumental vaginal delivery rate for June 2022 was 15.9% against a national target of 12%. The dashboard indicated the service had red flags in all recorded categories, however, there were areas of improvement demonstrated, for example, in massive postpartum haemorrhage.

A review of the NHS maternity screening key performance indicators from January to March 2022 indicated the service reached the achievable threshold in most screening categories which included fetal anomaly ultrasound and sickle cell and thalassaemia screening. The exception was the timeliness of antenatal screening which was at 48% against an acceptable threshold of 50% and an achievable threshold of 75%. The service had an action plan in place to address this decline in performance.

A review of the perinatal mortality review tool (PMRT) annual report from October 2021, indicated a comprehensive report with identified issues, contributory factors, RAG rated action plans and recommendations.

The service participated in relevant national clinical audits. The service participated in national audit programmes such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBRRACE), National diabetes in pregnancy audit, National Maternity and Perinatal Audit (NMPA) and the National Perinatal Mortality Review Tool (PMRT).

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a comprehensive audit and re-audit programme. The audit programme included the national audits and local audits. The audit programmes included e.g. perinatal mental health, obstetric health records and hypertension in pregnancy.

The service maternity dashboard was red, amber, green (RAG) rated and the target rates were clearly indicated. The service recorded the clinical performance indicators on a monthly basis.

Managers shared and made sure staff understood information from the audits. Managers and staff used the results to improve women's outcomes. The service had a comprehensive audit programme. Review of audit data after the inspection indicated the service shared audit results with the staff in the form of updates, newsletters and electronic messaging. Action plans were in place to improve outcomes, with responsibilities, dates and action to be taken. Repeat audit was in place to monitor the effectiveness of the changes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development, however, not everyone had received an appraisal.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The service did not always conduct annual appraisals with their staff. The appraisals for midwifery staff has been impacted by the staffing constraints and was below 50% in all areas of maternity including the community, against a trust target of 90%. The service had an action plan in place with processes put in place for line managers to complete appraisals. The target aim was to complete one appraisal per week per staff member trained. The action plan sat with the head of midwifery and included monthly monitoring and escalation. Appraisal compliance rates were a standing agenda item at the monthly Obstetric Governance meeting.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers made sure staff received any specialist training for their role. Staff that cared for women had a programme of required training in addition to mandatory training requirements. Medical and midwifery staff groups completed this specialist training, for example, Practical Obstetric Multi-Professional Training, (PROMPT) this formed part of the core competency framework for all clinical staff employed by maternity services.

Neonatal life support (NLS) was included as part of the PROMPT training. Data reviewed after the inspection indicated 87% of midwives and 91% of medical obstetric staff had completed NLS on PROMPT.

All staff that care for women in labour are required to undertake annual training and competency assessment on cardiotocography (CTG). Staff are assessed through a competency assessment tool and have to achieve 90% to pass the module. The seven modules include intrapartum CTG, fetal blood sampling and antenatal CTG. Review of data after the

inspection indicates the junior doctors were at 100% in all competencies and the delivery suite midwives at 80% in all competencies and at 100% in intrapartum CTG competency. The service holds monthly CTG study days led by the fetal monitoring midwives, CTG study days for newly qualified midwives and bespoke CTG training for international midwives.

A review of data after the inspection indicated 19% of the midwifery workforce were trained in newborn and infant physical examination (NIPE) screening and had an annual update. NIPE training was an additional continuing professional development training for midwives.

All student midwives had an allocated mentor for the sign off of their required competencies.

Managers gave all new staff a full induction tailored to their role before they started work. All newly qualified midwives went through a preceptorship programme and were supported to gain skills and experience within their role. The local head of midwifery met with all newly qualified midwives individually as part of their induction. All bank staff had to complete a full trust induction programme and a local induction for each clinical area they worked in.

The service had a comprehensive doctors in training induction process which included key documents, where to go for support and the clinical and educational supervision arrangements.

The midwives' induction included an orientation programme and checklists for each work area.

Staff induction procedures included identification badges, accessing online e-learning and an induction booklet which included key names and contact numbers.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were encouraged to discuss their training needs and aspirations outside of the appraisal process. Staff told us they could discuss training and development with their manager and would be encouraged to develop their skills and knowledge.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The junior doctors had a daily morning teaching session which included shared learning. Junior doctors told us the training and support received in the unit had been 'fantastic'. When poor performance was identified action plans for the doctor's practice were devised and followed through. Staff told us the action plans have worked well.

The service had objective structured assessment of technical skills (OSATS) as one of the assessment tools used in obstetric and gynaecology training. The OSATS assess the technical competency in the core procedures in obstetrics and gynaecology, for example, fetal blood sampling, manual removal of placenta and perineal repair. The competency sign-off must include at least two different assessors and include consultant sign-off in at least one of the assessments.

Doctors completed medical revalidation every five years. Data reviewed after the inspection indicated 100% of doctors are up-to-date.

The clinical educators supported the learning and development needs of staff. The service had a clinical practice facilitator who told us the service leads were determined training was not cancelled especially PROMPT and CTG training. The service also had access to clinical educators to ensure staff remained up to date with basic life support and neonatal life support skills.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service had suspended staff meetings during the pandemic. These had recently re-started. Staff had been kept informed and updated by managers through newsletters, emails and electronic messaging applications.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service continued to develop staff skills and knowledge despite the pandemic. The service had implemented physiological cardiotocography (CTG) interpretation and ensured staff had the training and support to successfully implement into practice.

Managers were able to give examples of staff development and progression, for example the specialist close monitoring unit (CMU) training. Managers were also able to give examples of individual training needs that had been identified and the support put in place.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. The service held multidisciplinary handover meetings to ensure the safe care and treatment of women. The service had specialist clinics held in conjunction with maternity. The service held a weekly anaesthetic clinic as well as speciality clinics such as diabetes. The service had established relationships and pathways with partner mental health organisations and safeguarding teams.

We observed the midwifery and medical staff worked well together and supported each other in the care of women and their babies.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had developed a medical pathway, in collaboration with other teams in order to establish a referral route for women who may present with medical needs that were not pregnancy related.

The service developed a close monitoring unit (CMU) for women who required a central venous line (CVL) after a major obstetric haemorrhage. Previously the women would have to be admitted to the high dependency unit and there would be separation between the mother and child. The CMU enabled the women to be cared for in the maternity unit, by specialist trained midwives, without separation from their baby.

The CMU had documentation and observation tools that were separate from the standard obstetric observation chart.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. Consultants held daily ward rounds within all clinical inpatient areas of the service. Since the Ockenden report the service had instigated evening ward rounds at the weekends. There was always access to a consultant on call when there was not a consultant present on site. The consultant on call rota was available in the delivery suite and contact numbers were displayed.

Maternity

Maternity services had a maternity triage 24 hours a day, seven days a week for women to contact if they experienced changes in fetal movements or vaginal bleeding. Emergency contact information about the service was easily accessible through the hospital website.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The service had access to diagnostic imaging, mental health services and pathology services 24 hours a day, seven days a week to provide timely diagnosis and treatment.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The service had information available in multiple languages on both the website and leaflet form. Service leaders told us they were keen to develop information available for women in accessible formats to suit the needs of the local population.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service assessed woman's health needs such as diabetes, smoking and vitamin D deficiency as part of the antenatal checks. Staff were able to give women information and where appropriate refer to specialist services.

Data received after the inspection indicated the last record keeping audit showed compliance with discussion of vitamin D at 41%. The service told us on reviewing the reasons for the low compliance, an issue was identified with the data transfer within the Maternity Information System (MIS). This has been escalated to the software provider as a matter of urgency.

Staff gave aftercare information to women prior to discharge. Staff told us due to staffing pressures it was not always possible to spend time with women to ensure they had and understood all the information that they needed.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff made sure women consented to treatment based on all the information available. All women we spoke with felt they had been given enough information, including risks and benefits, to make an informed decision over their care and treatment and that they were able to give informed consent. Women were able to give us examples of information they had been given and how they were asked for their views and preferences before consent to treatment.

Staff clearly recorded consent in the woman's records. A review of women's records indicated that consent was recorded in line with trust policy.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff we spoke with were able to explain the procedure if there were concerns over the woman's capacity to consent. Staff were supported by a dedicated mental health midwife.

Maternity

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Mental capacity act and deprivation of liberty safeguards was part of the mandatory training programme. All staff we spoke to knew how to access the policy online. The service had a dedicated mental health midwife and access to the wider mental health team for support and advice.

Review of data received after the inspection demonstrated maternity and midwifery staff had a training compliance of 77.27% for mental capacity act and consent training, against a trust target of 90%.

Is the service well-led?

Requires Improvement

Our rating for well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood but did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leaders at every level had the experience and capability to deliver effective leadership of the service. The leadership at all levels was knowledgeable about the issues and priorities for the service and understood the challenges and had action plans in place to address the concerns. However, they did not always have the systems and processes in place to establish oversight of the service and to support staff to maintain safe standards, for example, locking notes trolleys and closing fire doors.

The local service leaders had not maintained effective training and development of the staff, for example, safeguarding training and appraisals. The leaders had identified these as areas of concern and did have action plans in place to address them.

The service had a defined leadership structure with a director of midwifery, general manager and clinical director (women's) at trust level, they were the direct line of reporting for the local care unit managers. The leaders told us they had ready access and meetings with the executive team, with direct reporting lines to the medical director and chief nurse.

The trust had a non-executive director for maternity services, who also chaired the quality committee.

The local care unit level leadership consisted of a head of midwifery, service managers and clinical lead (obstetrics). The specialist midwives and ward managers reported into the local care unit leaders.

Leaders at every level were visible and approachable. Staff told us the service leaders and line managers were supportive and they felt able to approach the leadership team openly and honestly.

The service had developed specialist roles such as the bereavement midwife, mental health midwife and risk and governance midwife. Staff were encouraged to develop their skills for example the close monitoring unit (CMU) training.

Maternity

Managers we spoke with were proud of their staff and how the team had supported each other through the pandemic and the ongoing staffing challenges.

Vision and Strategy

The service was developing a vision for what it wanted to achieve and a strategy to turn it into action, it would be developed with all relevant stakeholders.

Prior to the trust merger the service had a strategy document under the women's and children services. As the maternity services were now delivered across two hospital sites the teams were developing a new maternity strategy across both sites.

The development of the strategy planned to involve all relevant stakeholders including staff and service users. The service had a phased approach to ensure effective engagement and planning. They were in phase 1 at the time of inspection.

The service had a set of values which were described by the acronym THRIVE. Teamwork, Honesty and openness, Respect, Inclusivity, Valuing people, Excellence.

Staff had a small card with the values on and the behaviours expected and how this was achieved, for example, Respect could be demonstrated by taking the time to actively listen and respond to women, colleagues and carers. We observed posters with the values displayed.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

The local leaders were encouraging and supportive towards the staff. The leaders respected and valued their staff and were proud of the care given to women who used the service. Managers were able to give examples of staff development and progression, for example the specialist close monitoring unit (CMU) training.

Local leaders told us of hospital wide staff events such as 'event in a tent', which was a staff engagement event. The event included a thank-you session and long service awards and was focused around staff.

The service was also promoting the Daisy Awards, which was for nurses or midwives who consistently demonstrate excellence.

Staff we spoke with confirmed that they felt encouraged and supported to raise concerns and action was taken when they raised concerns. Staff all told us the service had a learning culture and did not feel any concern over raising issues.

Women and their families were encouraged to give feedback to the service using the feedback forms, support groups or directly with a member of staff. All the women we spoke with on inspection confirmed they felt comfortable to raise any concerns with the staff.

All staff we spoke with told us that maternity was a close-knit team, staff supported each other at difficult times for example through the height of the pandemic. Staff worked as a team to deliver care to women despite the challenges they faced with the aged estate and staff vacancies.

The morale of midwifery staff was affected by the staffing pressures.

The 2021 staff survey results have been used by the trust to determine areas of success, areas for development and focus areas for 2022. The results indicated staff felt they had opportunities to show initiative in their role and they feel secure raising concerns of unsafe clinical practice, however, staff did not feel appraisal helped them improve how they do their job and they could not meet all the conflicting demands on their time.

The General Medical Council (GMC) survey 2022 for junior doctors rates overall satisfaction at 72.06%, with teamwork rated at 73.77%.

The trust had a Freedom to Speak Up Guardian, information provided by the trust showed that three concerns were raised by staff in the last 12 months. None of the concerns raised with the Freedom to Speak Up Guardian related to safety or clinical incidents.

Governance

Leaders did not always operate an effective governance process, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a well-defined governance structure at local service level and across site, however, the service did not always have effective processes in place to confirm staff were accessing up-to-date policies and that staff were following relevant guidance, for example, reporting when medicine temperatures were out of range.

The local governance support midwife, bereavement midwife, audit midwife and patient safety and risk manager reported to the local quality governance manager. The local quality governance manager reported to the cross site quality governance manager.

The trust held a monthly cross-site performance, safety and quality review meeting. This meeting had a standard agenda and was attended by midwifery and clinical representatives from both sites as well as the trust clinical director and director of midwifery. A review of the May and June 2022 minutes indicated updates were given from the local representatives as well as from trust level. Actions were clearly highlighted and the minutes included an action log.

The maternity safety and governance meeting was held monthly and was attended by a board non-executive director. A review of the April, May and June 2022 minutes indicated the meeting had standard agenda items which included updates and compliance. The maternity and perinatal safety champions had a confidential email inbox for feedback and suggestions.

The local service had regular governance meetings and a review of the obstetric governance meetings for April, May, June 2022 indicated the meeting had a standing agenda which included safeguarding, infection control and risk.

The service also had regular monthly triumvirate meetings which has a rolling action log. The log included comments, actions, deadlines and updates. Items on the log included staffing challenges.

Regular face-to-face staff meetings had been suspended during the pandemic, however, we were told these were now being re-started. The service had put regular email contact, newsletters and electronic messaging in place to keep staff updated and informed.

Maternity

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had introduced a risk assessment sticker system in the women's notes, however, there was an inconsistent approach to the use of the system and the service had not established an effective system to embed this into practice.

The service had a local maternity risk register which included a red, amber, green (RAG) rating, description of risk, action taken, risk owner and review date. The risk register included the risks that we had been informed of as part of the inspection including staffing levels, information technology and the maternity unit lifts.

The local Obstetric governance meetings discussed identified risks and action taken or in progress. Review of meeting minutes indicated risk was discussed and shared at the trust governance meetings and the local women's Luton site service meeting included updates from governance, finance and human resources.

The service had an electronic incident reporting system. All staff were encouraged to report incidents and risks on the system. Data reviewed after the inspection indicate the service had 143 open notifications which were currently under review. All incidents graded as moderate or severe harm are reviewed weekly in a multidisciplinary setting.

The service had plans, policies and standard operating procedures in place to cope with unexpected events, for example, baby abduction.

Information Management

The service did not always collect reliable data. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Local leaders told us the information technology (IT) system currently in use was a cause for concern. The data capture platform is currently on the maternity risk register and is RAG rated red. The service currently captures data for quarterly key performance and standards submissions to Public Health England (PHE) on an electronic spreadsheet. The number of data items was often too large causing the system to crash and lose data.

The service told us there were issues identified with the data transfer within the Maternity Information Systems and the data did not always pull through between the two systems used.

The service does have plans for an integrated IT system across the trust. Managers within maternity services were keen that any electronic system that was used would ensure that the data quality met the needs for reporting internally and externally.

The service used paper patient records, one set of records was held by the woman and the other by the service. The risk associated with dual documentation is on the risk register. The service did have electronic prescription and medicine management system. The service had plans to move to electronic patient records in the future.

Local and trust service leaders demonstrated that they understood the performance of the maternity service which included women's and staff views, safety and risks. Managers had a framework to oversee the quality and safety of patient care, which included the maternity dashboard and the regular audit programme.

Maternity

The service consistently submitted data to external organisations when required such as Healthcare Safety Investigation Branch (HSIB) and Care Quality Commission notifications. The service also participated in national audit programmes which required regular, accurate data notifications.

Engagement

Leaders and staff actively and openly engaged with service users, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service consistently worked to gain feedback from staff, service users and external stakeholders. Managers communicated important messages to staff through safety huddles, handovers, staff meetings and through the monthly 'risky news' newsletter.

The service had feedback mechanisms in place to gain the views of women including feedback forms, formal complaints and the friends and family test. The latest friends and family test results we saw displayed on the postnatal ward (Ward 33) notice board was 98.5%.

The service had actively sought to engage with the local community and had close links with the African mothers support group. They had plans in place to hold meetings in community locations to enable local engagement with women.

The service worked with the Maternity Voices Partnership and were members of the Bedford Luton and Milton Keynes (BLMK) health and care partnership. The BLMK had hosted a webinar which was available to the local community and had experts to answer questions including those about pregnancy, breast feeding and the COVID-19 vaccines in pregnancy.

The leadership at both local and trust level were committed to developing a service which was designed to meet the challenges of the local community and to ensure the voices of the staff and all relevant stakeholders were heard.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Leaders at all levels told us the service was committed to continuous learning and improvement. The local leaders were proud of the development of the development of the CMU. This enabled women and babies to stay together and developed the skills and knowledge of the staff.

The Birmingham Symptom Specific Obstetric Triage (BSOTS) was introduced to Luton and Dunstable Hospital in April 2020. This system ensured assessment and ongoing care followed standardised pathways. The system has been embedded into practice and reviewed. The learning and improvements from the implementation of the pathway had been shared.

The black and minority ethnic (BME) workstream worked with the maternity voices partnership to develop a poster to inform women about the risks to black women during the pandemic.