Bedford Hospital NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Bedford Hospital NHS Trust provides a range of hospital care services to over 270,000 people living predominantly in north and mid Bedfordshire and is the vascular hub for Bedfordshire, Luton and Dunstable, and Milton Keynes. The trust provides a full range of district general hospital services to its local population, with some links to hospitals in Luton and Dunstable, Milton Keynes and Cambridge.

There are approximately 425 inpatient beds and 28 day case beds within the hospital.

We carried out an announced comprehensive inspection of the trust from 15 to 17 December 2015. We undertook two unannounced inspections on 6 and 7 January 2016. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, allied health professionals, domestic staff and porters. We also spoke with staff individually.

Overall, we rated Bedford Hospital as requires improvement. We found improvements were needed to ensure that services were safe, effective, responsive to patient's needs and well-led. We found that caring was good. Patients were treated with dignity and respect and were provided with appropriate emotional support.

Four of the eight core services at Bedford Hospital were rated requires improvement (surgery, maternity and gynecology, children and young people and outpatient and diagnostics). Four services were rated as good (urgent and emergency care, medical care, critical care and end of life care).

Our key findings were as follows:

- Staff were kind and caring and treated people with dignity and respect.
- Overall the hospital was clean, hygienic and well maintained.
- Equipment was not always appropriately checked and maintained.
- Vacancy rates had improved in November 2015 to 6.1% but remained worse than the trust target of 5%. Nursing vacancies averaged 9.1%. The trust had identified this as a risk and a recruitment programme was underway.
- Temporary staff were used to fill vacant shifts. An induction process was followed for temporary staff.
- Not all staff had completed mandatory training and not all relevant staff had not completed other recommended training for example, Advanced Paediatric Life Support.
- Between June 2014 and June 2015 the trust had reported one case of Methicillin-resistant Staphylococcus Aureus (MRSA), this was in May 2015. There were 13 reported Clostridium difficile cases and four reported Methicillin Sensitive Staphylococcus Aureus (MSSA) cases. Incidences were similar to or better than the England average.
- Most patients were complimentary about the hospital food and women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 85% in May 2015 which was better than the national average of 75%.
- Patient's pain was well managed and none of the patients we spoke with reported being in pain.
- Patients at the end of life were given adequate pain relief and anticipatory prescribing was used to manage symptoms.
- The trust were generally meeting the national targets set regarding patients access to treatment in surgical and outpatient settings.
- The trust were meeting the standard for patients admitted, referred or discharged from the emergency department within four hours.
- There were governance processes in place to provide oversight of incident reporting and management, including categorisation of risk and harm. However,

Summary of findings

we were not assured demonstrated a sufficient depth of analysis or learningand therefore we were not assured that improvements in practice to prevent reoccurrence had been achieved.

- We saw evidence of learning from some incidents but were not assured of the ongoing monitoring of changes made and therefore their sustainability.
- Staff generally felt they were well supported at their ward or department level.
- Staff reported on the whole executive directors were visible.

We saw several areas of outstanding practice including:

- The hospital offered Endovascular stent-grafts for popliteal aneurysms, which is an alternative method to open surgery, early indication suggest it is safer and more effective for the patients.
- Image guidance for endoscopic sinus and skull base surgery is used for sino-nasal tumours, revision sinus surgery and disease abutting the optic nerve, carotid artery and skull base. For patients it means safe surgery, closer to home.
- One stop neck lump clinic. This speeds up the diagnosis of head and neck cancer by Tru-Cut biopsy solid tumours and avoids general anaesthetics in most cases, with the potential to speed up treatment.
- The critical care complex had designed and built an attachable portable unit for the end of a patient's bed, to prevent disruption to the patient's care and welfare. The unit was used when patients needed to go for a computerised tomography (CT) scan or a magnetic resonance imaging (MRI).
- A high risk birthing pool pathway was developed and implemented at the beginning of 2015. This meant that women with high risk pregnancies had the opportunity to experience the benefits of water whilst in labour. Midwives who were involved with the development of this project were selected as finalists in the Royal College of Midwives Innovation Awards 2015.
- Dementia facilities met the needs of patients living with dementia. Facilities included a cinema area, activity tables, coloured and picture coded bays and the inclusion of the wanderguard system. Under bed lighting assisted patients to differentiate between beds and flooring at night, and reported falls had decreased since the lighting was implemented.

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

Importantly, the trust must:

- The trust must ensure patients privacy and dignity is always maintained at all times.
- The trust must ensure all reasonable efforts are made to make sure that discussions about care and treatment only take place where they cannot be overheard.
- The trust must ensure patients always have privacy when they receive treatment or when they used washing facilities.
- The trust must ensure that where a person lacks capacity to make an informed decision or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust must improve the incident reporting process to ensure all incidents are reported, including those associated with staffing levels.
- The trust must ensure lessons learnt and actions taken from never events, incidents and complaints are shared across all staff.
- The trust must ensure risk registers reflect the risks within the trust.
- The trust must ensure effective and timely governance oversight of incident management, that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly; including categorisation of risk and harm, particularly in maternity services.
- The trust must ensure patient records are accurate, complete and fit for purpose, including 'do not attempt cardio-pulmonary resuscitation' forms.
- The trust must ensure that systems and processes are in place to ensure the documentation and monitoring of the cleanliness of equipment.

Summary of findings

- The trust must ensure that policies are comprehensive.
- The trust must ensure there are the appropriate numbers of qualified paediatric staff in the emergency department and paediatric unit to meet standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing.
- The trust should ensure that where staffing fill rates do not meet trust target, associated risks are identified and mitigated.
- There must be sufficient numbers of staff trained to the expected standard to give life support to paediatric patients.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Bedford Hospital NHS Trust

Bedford Hospital NHS Trust provides a range of hospital care services to over 270,000 people living predominantly in north and mid Bedfordshire and is the vascular hub for Bedfordshire, Luton and Dunstable, and Milton Keynes. The trust provides a full range of district general hospital services to its local population, with some links to hospitals in Luton and Dunstable, Milton Keynes and Cambridge.

There are approximately 425 inpatient beds of which 44 are maternity and 10 are critical care, plus 28 day case beds within the hospital.

In 2014/15 the trust's revenue was £164.1m. There was a deficit of £19.8m for the 2014/15 financial year. At the end of November 2015, there was a cumulative income and expenditure performance of £13.6m deficit, which was almost £2m higher than the forecast deficit of £11.6m.

The trust is not a foundation trust and the inspection was not part of a foundation trust application.

We carried out an announced comprehensive inspection of the trust as part of our in-depth hospital inspection programme, from 15 to 17 December 2015. We undertook two unannounced inspections on 6 and 7 January 2016.

The trust was an example of a moderate risk trust according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, allied health professionals, domestic staff and porters. We also spoke with staff individually.

The inspection team inspected the following eight core services at Bedford Hospital

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

Our inspection team

Our inspection team was led by:

Chair: Dr Mike Lambert, Consultant, Norfolk & Norwich University Hospitals NHS Foundation Trust

Team Leader: Helen Richardson, Care Quality Commission

The team included 13 CQC inspectors and a variety of specialists including governance leads, medical consultants and nurses, senior managers, a surgical nurse, an anaesthetist, a cardiac nurse practitioner nurse, paediatric nurses, a consultant obstetrician, a consultant neonatologist, midwives, allied health professionals, a palliative care consultant, a child safeguarding lead, junior doctors, a student nurse and experts by experience who had experience of using services.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

• Is it responsive of people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we held about Bedford Hospital NHS Trust and asked other organisations to share what they knew about the trust. These included the Clinical Commissioning Group, the Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We held a listening event in the evening before the inspection where people shared their views and experiences of services provided by Bedford Hospital NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection from 15 to 17 December 2015 and unannounced inspections on the 6 and 7 January 2016.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, allied health professionals, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Bedford Hospital NHS Trust.

What people who use the trust's services say

During and post inspection we talked to patients across the trust. Most of the responses we received were positive about the services they had received with praise mainly relating to the level of care and compassion staff had shown them. Examples of comments included:

- "Fantastic, they (staff) look after me really well"
- "Staff go above and beyond."
- "It's good food, it's very fresh"
- "Services have improved"
- "Staff here are friendly and make regular checks"
- "Could not fault them (staff)"
- "We are kept up to date"

Facts and data about this trust

Bedford Hospital NHS Trust provides a range of hospital care services to over 270,000 people living predominantly in north and mid Bedfordshire and is the vascular hub for Bedfordshire, Luton and Dunstable, and Milton Keynes. The trust provides a full range of district general hospital services to its local population, with some links to hospitals in Luton and Dunstable, Milton Keynes and Cambridge.

The trust employs 2368 whole time equivalent (WTE) staff, of whom 302 WTE are medical, 742 WTE are nursing and 1324 WTE are other staff including allied health professionals, ancillary and administration staff.

The hospital has 425 inpatient beds and 28 day case beds. It received 67,139 emergency department attendances and had 294,517 outpatient attendances for the year 2014/15. For 2014/15 the trust also had 20,777 non-elective admissions and 26,774 elective admissions (of which 21,746 were day case admissions). Almost 25% of attendances resulted in an admission, this was higher than the England average of 22.2%.

Between June 2014 and March 2015, bed occupancy for the trust averaged 95%. Bed occupancy rates had been consistently over 90% for each quarter and were worse than the England average.

Summary of findings

This was above the level of 85% at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

In 2014/15 the trust's revenue was £164.1m. There was a deficit of £19.8m for the 2014/15 financial year. At the end of November 2015, there was a cumulative income and expenditure performance of £13.6m deficit, which was almost £2m higher than the forecast deficit of £11.6m.

The two local Unitary Authorities (UA), Bedford UA and Central Bedfordshire UA, differed in their deprivation profiles. Bedford was ranked 148th out of 326 in the 2015 English Indices of Deprivation, where one was the most deprived. Central Bedfordshire was 260th.

Bedford UA had five out of 32 (16%) indicators significantly worse than the England average and three of those were in the eight diseases and poor health category (prevalence of opiate and/or crack use; recorded diabetes; and new sexually transmitted infections). Nine of the 32 (28%) indicators were significantly better than England, including smoking prevalence and physically active adults. Central Bedfordshire UA had only one (3%) indicator significantly worse than England (excess weight in adults) whereas 20 of the 32 (63%) indicators were significantly better.

Mortality was slightly above the expected range of 100 with a value of 102. However, this had improved compared to the preceding period. The trust were implemented a series of actions to address this concern.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust required improvement with regards to safety. We found that five of the eight core services in the trust required improvement for being safe. Medical care, critical care and end of life care were rated good for being safe. In the emergency department, we identified environments that posed ligature points and therefore was a risk to patient safety. The department did not have a secure paediatric area in line with Royal College of Paediatrics and Child Health guidance. We escalated this to the executive team who put an action plan in place to minimise risk to patients. Arrangements were in place for reporting safeguarding concerns. However, staff did not always follow trust policy when patients were already receiving support from Child and Adolescent Mental Health Services (CAMHS) and/or social services. There had been 9.2 incidents per 100 patient admissions between August 2014 and July 2015, which was higher than the national average of 8.4. Of these 88% were categorised as causing no harm or low harm. We saw learning from the two never events reported between August 2014 and July 2015. There had been a cluster of maternity incidents that did not always demonstrate a sufficient depth of analysis or learning and therefore, we were not assured that improvements in practice to prevent reoccurrence had been achieved. This meant that an effective system was not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients in the service. In response to our concerns, the trust redacted the local maternity risk policy and strengthened its trust serious incident policy to include identification of immediate action to be take post incident, identification of immediate learning for dissemination across the trust, the implementation of trust patient safety alert and updated templates for serious incidentinvestigation reports to included learning and conflict of interest. Medicine incidents were reported. We found medicine out of date and medicines not always stored safely and securely to prevent theft, damage or misuse. We raised this with the trust who implemented processes to monitor the storage and date of medicines.	**Requires improvement** 

Summary of findings

We found some items of equipment were out of date. We raised this with the trust who implemented a monthly check of consumables.

Areas were generally clean.

The trust reported an overall vacancy rate of 6.05% in November 2015 compared with 9.5% in November 2014 demonstrating progress towards the target of less than 5%. Bank and agency staff filled vacant shifts. Nursing fill rates and averaged 96.5% between April and November 2015.

Most of the staff we spoke with were aware Duty of Candour. We saw evidence from incident reports that patients were informed by the trust in a timely way if something had gone wrong relating to their care.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Most of the staff we spoke with were aware Duty of Candour, in that they knew that if there was an incident or a complaint that the trust would be open with the patient. There were posters in some areas, such as in ED, to support the staff's knowledge.
- Duty of candour training was provided for consultants, matrons and ward managers, but compliance rates were 12%, 11% and 5%, respectively. This did not meet the trust target of 100%.
- We saw evidence from incident reports that patients were informed by the trust in a timely way if something had gone wrong relating to their care.

Safeguarding

- For September 2015, across the trust there was 82% compliance with adult's level 1 safeguarding training and 87% with children level 1 safeguarding training. This did not meet the trust target of 100%.
- Most staff we spoke with had a good understanding of how to recognise safeguarding concerns and how to make a referral. Safeguarding resource folders were available on all wards and were reviewed and updated on a monthly basis.

Summary of findings

- The trust employed an adult safeguarding lead nurse, and had a named nurse, doctor and midwife responsible for safeguarding children. They were responsible for quality, with regards to safeguarding, policy development and training.
- There was a lead learning disability liaison nurse responsible for safeguarding patients with a learning disability.
- There had been 269 safeguarding alerts raised by the trust in 2014/15. An increase of 32 alerts on 2013/14. The trust believed this was due to an increased safeguarding awareness among staff.
- The director of nursing and patient services chaired the monthly Bedford Hospital safeguarding board meeting, with key stakeholders in attendance including Bedfordshire CCG representation. This included review and monitoring of all open cases/safeguarding investigations.
- The safeguarding lead chaired Bedford Hospital safeguarding adults operational monthly meetings that focused on safeguarding issues that had affected individuals or ward areas and allowed for in-depth review. The safeguarding lead also attended the daily operational quality meeting to discuss emerging safeguarding issues and collect referrals, provide guidance, direction and practical help to staff attending the meeting.
- Twelve nursing staff had successfully completed a Safeguarding Adults Champions Course with the University of Bedfordshire. A further course has been commissioned to commence in October 2015 for 25 members of staff.
- There was a safeguarding children policy and safeguarding adults' policy in place. The policy was approved in April 2014 and due for review in April 2016. The policy set out responsibilities and arrangements for safeguarding. The policy did not make reference to female genital mutilation (FGM). However, there was a separate multi-agency pathway for under 18s in mental health crisis and a separate policy on FGM, there was also a section on the trust's intranet on safeguarding arrangements in FGM cases.
- We reviewed a sample of five paediatric patient notes who had been admitted with self harm related concerns. The patients were already under the care of CAMHS and/or social services. According with trust policy an information sharing form and safeguarding referral should have been completed for all of these patients. We found that referrals to social services had not been made for four of the patients as per the trust's policy. Sharing information forms had been completed for two of the patients but not for the remaining three. This meant that the trust's own policy had not been followed.

- We raised this with the trust, who told us that none of these patients required a safeguarding referral because their needs were already met by CAMHS and/or social services, and that all actions had been completed with clear multiagency involvement.

Incidents

- Most staff told us that they were familiar with the incident reporting process. However, staff reported receiving feedback from incidents varied across the trust.
- There had been 71 serious incidents and 4,601 incidents reported to the National Reporting and learning System (NRLS) between August 2014 and July 2015. This equated to 9.2 incidents per 100 admissions which was higher than the national average of 8.4. Of these 88% were categorised as causing no harm or low harm. NRLS reporting flagged as risk on the May 2015 CQC Intelligent Monitoring report.
- Between June 2014 and June 2015 the trust had reported one case of Methicillin-resistant Staphylococcus Aureus (MRSA), this was in May 2015. There were 13 reported Clostridium difficile cases and four reported Methicillin Sensitive Staphylococcus Aureus (MSSA) cases. Incidences were similar to or better than the England average.
- Between July 2014 and July 2015 the trust had recorded via the NHS Safety Thermometer 34 pressure ulcers, category two, three or four; 40 falls with harm; and 25 catheter associated urinary tract infections.
- There had been two 'never events' in the trust between August 2014 and July 15 which occurred within the surgical services and another in outpatients. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. One never event was where a patient received the wrong blood transfusion in surgical services and a root cause analysis was carried out with lesson learnt identified and actions implemented as a result. The other was a wrong site surgery relating to a radiology procedure, again lessons were learnt and implemented.
- The records we reviewed showed that the World Health Organisation's Five Steps to Safer Surgery checklist had been completed. Audit between January and October 2015 showed a 99% compliance with the completion of the checklist. This meant patients were protected from avoidable harm.
- At the time of our inspection, we found it difficult to determine how many SIs there had been because of inconsistent risk

management and allocation of the level of harm to incidents. After the inspection, the trust provided us with information that nine SIs were reported to STEIS between April and December 2015. Of which there were three neonatal deaths (categorised as unavoidable), two gynaecology SIs (categorised as unavoidable), one maternal death (categorised as unavoidable), two stillbirths (one was categorised unavoidable and one was categorised as avoidable), and one complication post caesarean section.

- Although the trust board was always aware of the incidents in maternity, we saw evidence that demonstrated that the trust was inconsistent in its review and analysis of incidents. Senior staff did not assure us that investigations were monitored and action plans reviewed and closed in a timely manner. The root cause analysis in relation to individual serious incidents did not always demonstrate a sufficient depth of analysis or learning. Therefore, we were not assured that improvements in practice to prevent reoccurrence had been achieved. In response to our concerns, the trust redacted the local maternity risk policy and strengthened its trust serious incident policy to include identification of immediate action to be take post incident, identification of immediate learning for dissemination across the trust, the implementation of trust patient safety alert and updated templates for serious incidentinvestigation reports to included learning and conflict of interest. Following our inspection, the trust commissioned an external review of maternity services which would include incident management.

Medicines

- Medicine incidents were reported.
- We found medicine out of date and medicines not always stored safely and securely to prevent theft, damage or misuse. We raised this with the trust who then implemented processes to monitor the storage and date of medicines.
- We found control drugs records were not fully completed in accordance with the regulations. We saw examples in the emergency department, where the quantity used had not been recorded, and errors in the register had not been corrected in line with national guidance. We saw the daily stock check was not always recorded in line with trust policy, so there was a risk the identification of discrepancies could be delayed.
- All Emergency Nurse Practitioners (ENPs) within the emergency department were independent prescribers. This meant that patients could have medications, such as antibiotics and pain relief, prescribed without seeing a doctor.

- All records we reviewed contained patient's allergy status and this was confirmed with patients.
- In the imaging department we found that radiographers were administering intravenous medicines, without a signed prescription or a patent group directive (PGD) in place. A PGD is used when prescription only medicines are administered to groups of patients without individual prescriptions. They are commonly used when medicine is used as a routine, for example, contrast media. Healthcare workers, such as nurses and radiographers should be trained to administer PGDs. Radiology and radiography staff were not sufficiently aware of the need for prescriptions. We raised this with the trust at the time of inspection who took action to address this.

Assessing and responding to patient risk

- Ambulance handover times did not always meet the national targets.
- Patient observations had been completed using the National Early Warning Score (NEWS). A scoring system which helps to detect if a patient's condition deteriorates. The timelines for repeating observations and escalating concerns had been followed in all cases. Risk assessments were completed in line with the relevant guidance and management plans were completed and followed as a result to mitigate risk.
- A paediatric early warning score (PEWS) tool was used to assess, monitor and manage deteriorating patients on the children's ward. Tools had been completed as required for most patients. However, we found observations were not always completed in accordance with agreed timeframes.
- The pre-operative screening process did not ensure that all patients who required pre-operative assessment attended for pre-operative assessment prior to their operation. This meant that there was a risk patients may not have been fully informed about their procedure, had all risks identified and had all relevant tests carried out before arriving for surgery. Following the inspection, the trust informed us that an additional safety check had been implemented, to track the attendance of patients.

Staffing

- Between April and October 2015 the overall trust average vacancy rate was 6.7%, reducing 6% in November. The target was less than 5%. Inability to recruit and retain to posts,

causing high temporary staffing spend across the trust was categorised high risk on the trusts risk register. A recruitment programme was ongoing, including oversees and local recruitment.

- There was a reliance on bank and agency nursing staff to fill vacant shifts. In November 2015 the average use of bank and agency nurses across the trust was 13%, higher than the national average. Between April and November 2015 the trust usage was 14.3%, although this was reducing, it did not meet the trust target of 12%. Total agency spend was £823k in November 2015, £170k lower than October 2015 and the lowest monthly spend since April 2015. However, spend on agency staff remained £559k above budget.
- An induction process was followed on each ward for bank and agency staff.
- Nursing fill rates and averaged 96.5% between April and November 2015. This had improved to 98% for November 2015, meeting the trust target of 95%.
- However, nurse staffing arrangements on the paediatric unit were not sufficient to meet demand. We raised this with the trust who took prompt action to address this.
- According to the Royal College of Nursing, 'Defining Staffing' guidance, at least one nurse per shift in each clinical area (ward/department) should be trained in Advanced Paediatric Life Support (APLS)/ European Paediatric Life Support Training (EPLS) depending on the service need. Nursing staff working on the paediatric ward had not completed APLS or EPLS training and were therefore unable to the meet the Royal College of Nursing guidance. Intermediate Paediatric Life Support (IPLS) training was provided for staff. We identified a shift in November 2015 where no nursing staff working had completed IPLS. This placed patients at risk because there were not enough suitably skilled staff to provide care if patients needed life support. We raised this with the trust. The trust provided us with an action plan to ensure nurses completed their APLS training and that all shifts had at least one IPLS trained nurse on duty.
- Consultant cover was provided in the emergency department for 14 hours per day Monday to Friday and 10 hours per day at weekends. This did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in all EDs for 16 hours a day, 7 days a week as a minimum.
- The overall trust staff mandatory training compliance for November 2015 was 79%. This did not meet the trust target of 90%.

Summary of findings

- The trust had a governance system in place which gave assurance that all doctors and nurses were registered whilst at work.

Equipment and Environment

- The emergency department did not have a secure paediatric area in line with Royal College of Paediatrics and Child Health guidance. This had not been identified as a risk by the trust. We escalated this to the executive team who put an action plan in place to minimise risk to patients.
- Patients with mental health conditions were placed in areas that were not compliant with RCEM guidance in the emergency department. For instance, there were ligature points or object that could be used as missiles. These areas had not been identified as a risk by the trust. We raised this with the trust and an action plan was implemented to reduce risk to patients and staff including staff personal panic alarms, removal of ligature points and constant observation of patients with mental health conditions in the department.
- Resuscitation equipment was not always checked in line with trust policy in the emergency department, all medical wards and the paediatric unit.
- Areas were generally clean. Cleaning schedules were available for cleaning the environment and equipment. However, at the time of inspection the ward managers and cleaners were unable to locate these when asked. Audits were completed on a monthly basis and compliance presented on the nursing quality dashboard.
- Most, but not all equipment had received portable appliance testing to ensure they were safe for use in accordance with trust policy.
- We found some items of equipment were out of date, including a tracheostomy set that expired in 2008 and a chest drain that expired in 2012 in the emergency department. We raised this with ward staff. Following our inspection, the trust implemented a monthly check of consumables.

Are services at this trust effective?

Requires improvement 

The trust required improvement with regards to effectiveness. We found that two of the seven services rated within the trust required improvement and five services were rated good for effectiveness.

Summary of findings

Although the latest data showed improvements, the Summary Hospital-level Mortality Indicator (SHMI) indicated more patients were dying than would be expected between May and October 2015. This had been reported to the trust board and an action plan was in place to improve results.

Patients with a 'Do Not Attempt Cardio-Pulmonary Resuscitation' form in place, did not always have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.

Policies and clinical assessments were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.

We saw some good examples of multi-disciplinary working across the trust. Staff appeared to know each other well and worked together as a team in most services.

Evidence based care and treatment

- Policies were based on national guidance produced by NICE and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- The emergency department used a number of nationally recognised pathways known as Clinical Standards for Emergency Departments' guidelines including those for sepsis, stroke and diabetic ketone acidosis.
- At the time of our inspection, we observed that guidelines were mostly in date.
- Patients clinical assessments were comprehensive, covering all health (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs

Patient outcomes

- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In the last published data, the trust's SHMI for the period April 2014 to March 2015 was 102.3 down from 103.5 for the preceding period. This was comparable to the national average of 100. The trust's board meeting minutes of January 2016, reported that the number of excess deaths decreased from 37.5 to 25.8.and the crude mortality for the two periods was relatively consistent at 3.7% (January to December 2014) and 3.9% (April 2014 to March 2015).

Summary of findings

- The SHMI showed the trust was worse than peer group in number of deaths for high risk groups between May and October 2015. This included the mortality rate for myocardial infarction (MI) of 10% against peer average of 8%. The rate for patients 75 years or older was reviewed between November 2014 and October 2015. There were 15 deaths giving a mortality rate of 20%, worse than the small hospital peer average of 13%. Mortality review tracking systems were in place including reviews of nursing and medical notes and findings were discussed at the monthly mortality review group. The trust was in the process of implementing the Trust Development Authority's national toolkit and peer review system for mortality.
- The average emergency department re-attendance rate within seven days was 6.7% between March 2013 and July 2015. This was worse than the standard of 5.5% set by the Department of Health. However, this was better than the England average for 26 of 28 (93%) months between March 2013 and July 2015.
- The trust was better than the England average for elective readmission risks at 86 for elective surgery and 82 for non-elective surgery compared to the England ratio of 100 patients. This meant that following surgery patients were at a lower risk of readmission than other hospitals in England

Multidisciplinary working

- We saw some good examples of multi-disciplinary working across the trust. Staff appeared to know each other well and worked together as a team in most services.
- Wards operated regular and effective multidisciplinary ward rounds which ensured a coordinated and focussed approach to care planning and discharge planning.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. We saw MCA assessments for decisions around provision of falls prevention equipment and blood transfusion.
- We were told that there had been 102 DoLS applications in 2014/15. Staff we spoke to understood the Deprivation of Liberty Safeguards and explained the process they would follow

Summary of findings

if they felt a patient was at risk of harm to themselves or others. Audits had taken place in regards to staff's understanding of the DoLS and had shown increased knowledge within inpatient settings, particularly care of the elderly wards.

- Patients did not always have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. We looked at 32 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms across all ward areas and the emergency department. 16 forms stated that the doctor had not informed the patient directly where a clinical decision for a DNACPR had been made. In these cases, there was no formal mental capacity assessment of the patient's ability to understand this decision. The DNACPR policy did not prompt staff to complete a capacity assessment as part of the decision making process.

Are services at this trust caring?

Good

We rated all trust services as good for caring.

Staff were caring and compassionate to patient needs and treated patients with dignity and respect.

Most patient's felt supported and most would recommend the trust to their family and friends.

Patients said they were kept informed about and felt involved in the treatment received. We observed staff demonstrating good communication skills during interactions with patients.

Compassionate care

- We witnessed patients treated with compassion, dignity and respect.
- We observed caring and compassionate interactions between staff and patients.
- Most patient's felt supported and well-cared.
- Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.
- Patient feedback from the NHS Friends and Family Test (FFT) showed that between July 2014 and June 2015, the trust performed worse than the England average. However, scores substantially improved over the period, from 85% to 95% of patients reporting they would recommend the trust to their family and friends. The November 2015 trust board paper indicated that there had been improvements in the inpatient, outpatient and paediatric responses, but deteriorating results

in the emergency department and maternity. The trust had actions in place to expand the use of patient experience videos to target training to specific problem areas such as ED and maternity.

Understanding and involvement of patients and those close to them

- Most patients felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff generally communicated in a way that patients could understand and was appropriate and respectful.
- Family members generally felt well supported by staff and told us staff explained things in a way they could understand to enable them to support their relative.

Emotional support

- A chaplaincy service was available for all religions were required. The chaplaincy service provided a remembrance service annually.
- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment, for example staff would spend longer time with patient that were upset and a private room would be made available if required.
- The Cancer Patient Experience Survey for 2014 were similar to the scores from 2012/13. The trust scored in the bottom 20% of all trusts for nine out of the 34 questions including patients being able to discuss worries or fears with staff. The trust scored in the top 20% of trusts for six questions, including staff explaining how the operation had gone in a way patients could understand.
- Performance in the CQC inpatient survey for 2014 was 'about the same' as other trusts with the exception of delayed discharges, which was worse. Although the trust sored 'about the same' as other trusts, talking to someone about worries and fears scored poorly. This finding was similar to the Cancer Patient Experience Survey for 2014.

Are services at this trust responsive?

Requires improvement

We rated the trust as requiring improvement with regards to being responsive. We found that two of the eight core services in the trust required improvement for being responsive. The other six core services were rated good for being responsive.

The trust was generally meeting the national targets set regarding patients access to treatment.

Summary of findings

The emergency department had met the Department of Health target to admit, transfer or discharge 95% of patients within four hours of arrival since January 2015, with the exception of four weeks. The department had performed better than the England average since October 2014.

Between June 2014 and March 2015, bed occupancy for the trust averaged 95%. Bed occupancy rates had been consistently over 90% for each quarter and were worse than the England average. This was above the level of 85% at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

There were excellent facilities to meet the needs of patients living with dementia. The trust had implemented processes to meet patient needs.

Complaints were managed in line with trust policy and action plans were in place to address complaint themes. Plans were in place to reduce the trust response time target, to improve complainant satisfaction.

Service planning and delivery to meet the needs of local people

- The trust was working with key stakeholders to ensure that health and social services met the changing needs of the local area.
- Planning of delivery of services was coordinated at daily bed management meetings. The trust had escalation areas that could be used to meet increased demand for beds. This included the placement of additional beds on some wards, such as Elizabeth ward and using the Victoria day unit to provide overnight care for planned discharges. The hospital had recently implemented hospital at home and clinical navigation teams to support prompt discharge and care at home, to ease pressure on acute beds and provide care locally.
- The trust did not provide a full time hyper acute stroke service. Thrombolysis (treatment for strokes) was provided by the trust between 9am and 5pm Monday to Friday. Out of these hours patients were transferred to Luton and Dunstable Hospital for treatment. The trust reported that patients who had been admitted with a stroke were nursed on Howard stroke ward for an average of 92% of time in December 2015, where there were four hyper acute stroke beds available.

Meeting people's individual needs

- All staff we spoke with showed a good awareness and knowledge of equality and diversity and gave examples of how they previously had to alter their care to ensure patient's beliefs were respected.
- Staff knew how to access interpreting services.
- A range of leaflets relating to illness and injury advice were available for patients. However, most were only available in English and not available in any other languages.
- Adult and child mental health services were available upon referral, provided by the crisis team and CAMHS. Staff told us that although there was sometimes a delay in their attendance, they generally had good working relationships. CAMHS covering the emergency department did not accept referrals out of hours. This meant that children and young people had to be admitted to the paediatric ward overnight and at weekends. There was a risk that mental health assessments and support was delayed. This was not identified on the directorates risk register. However, we did not see any incident reports relating to a delay in response from CAMHS and evidence was not collated by the emergency department to reflect delays.

Dementia

- The dementia lead nurse told us the trust had completed a stakeholder engagement event to help formulate a new trust dementia strategy. This would link with the local authority, and was out to consultation.
- Bedford Hospital officially opened new dementia facilities on Elizabeth and Harpur wards in 2015. Facilities included a cinema area, activity tables and the inclusion of the wanderguard system. Bays were colour coded with a different picture above bed spaces to help patients identify their bed. Under bed lighting had been introduced to assist patients to differentiate between beds and flooring at night. Reported falls had decrease since the lighting was implemented, from 87 reported falls in 2014, to 69 in 2015 on Harpur ward. The wards used a "Tag" system whereby patients with confusion or at high risk of falls were cohorted into one bay. A staff member was allocated to the area at all times.
- The Alzheimer's Society offered advice and support clinics on Elizabeth and Harpur ward for patients with Alzheimer's dementia and/or their carers.
- Harpur ward nursing staff told us they worked closely with community teams to promote an early discharge of patients living with dementia. They reported keeping in touch with care providers to keep them informed of any changes to patients conditions. This was deemed to help prevent readmissions to

hospital due to team recognition of patient deterioration. The nursing team worked with the dementia care speciality nurse and the community matron to keep staff informed of changes in care and condition.
- We saw activity blankets, memory tables and boxes in use across medicine wards for patients living with dementia. Staff reported that the activity blankets were made by staff in their own time.
- We saw the 'this is me' document in patient records, completed by relatives appropriately. These helped staff to meet the specific needs of patients living with dementia.
- Medical records showed delirium and dementia screening assessments had been completed where required.
- However, in the emergency department, we saw minimal information or guidance on caring for patients living with dementia. Staff had limited knowledge of caring for those living with dementia and tools available were not utilised.

Access and flow

- Like many trusts in England, Bedford Hospital NHS Trust was busy. Between June 2014 and March 2015, bed occupancy for the trust averaged 95%. Bed occupancy rates had been consistently over 90% for each quarter and were worse than the England average. This was above the level of 85% at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The department had met the 95% standard since January 2015, and performed better than the England average since October 2014. The performance standard was not met by the department for four weeks across December 2014 and January 2015, but performance was similar to or better than the England average during these weeks.
- Between January 2013 and June 2015 the median monthly time to treatment was 52 minutes. This met the standard of 60 minutes and was similar to the England monthly median of 53 minutes. The trust did not meet the standard for two of the 30 months.
- The percentage of patients waiting four to 12 hours in the emergency department from the decision to admit had been better than the England average between October 2014 and September 2015.
- An escalation plan was in place to enable staff to raise acuity and capacity issues with senior hospital staff. The escalation

level of the emergency department was discussed during the hospital's operations meetings which occurred three times daily. We saw managerial staff within the emergency department assist with flow, keeping staff informed of which escalation areas were open and any other actions taken to improve flow within the trust.

- The percentage of surgical patients meeting the 18 week referral to treatment target had improved overall. In November 2015 all specialities were complaint, apart from trauma and orthopaedics which met the target for 92% of patients.
- Between November 2014 and October 2015 94% of cancer patients were seen by a specialist within two weeks of an urgent GP referral. This was in line with the national standard.
- The trust met the national standard that 92% of patients waiting to start treatment (at the end of each month) or 'incomplete pathways' should start consultant-led treatment within 18 weeks of referral between July 2013 and August 2015. The trust also performed better than the England average for this time period.
- Since January 2014, the trust had performed well to provide patients with swift appointments for diagnostic services. A very small percentage of patients, often less than 0.5%, waited six or more weeks for diagnostic tests. This was better than the England average from January 2014 to August 2015.

Learning from complaints and concerns

- Systems and processes were in place to advise patients and relatives how to make a complaint. Information and leaflets about the complaints process was displayed across the trust.
- Reported complaints were in line with the trust's policy. Complaints could be raised in a variety of ways, in person, verbally, in writing and electronically.
- Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with a concern directly.
- The patient experience lead/complaints manager was responsible for managing complaints and there was a non-executive director lead for patient experience. The quality and clinical risk committee (QCRC) chaired by a non-executive director, reviewed the patient experience quarterly assurance report which included complaints and compliments, and associated themes. From April 2015 complainant feedback was monitored via a survey sent to approximately 30% of complainants. The results showed that complainants were unhappy with the length of time they had to wait for a final

response from the trust. In response, the patient experience lead told us that the team were planning to reduce the current 45 working day target to 40 days by the end of January 2016, with a further target of 35 days by June 2016.

- We saw the gap between open and closed complaints was narrowing. For example, in quarter 1 2015 there were 89 complaints and 84 were closed.
- Between April and November 2015 the trust had received 198 complaints. The top five themes of complaints and PALS for 2015 were:
  - All aspects of clinical treatment
  - Communication
  - Attitude of staff
  - Admission and discharge
  - Appointment cancellation and delay
- A programme of work was planned in line with the quality improvement strategy. The programme focussed on key work streams to address areas of improvement identified from trust wide feedback, including the inpatient survey and complaints. This work was to be monitored through a quarterly report to the quality board.
- Every trust board meeting included a patient story to highlight patient experience, outcomes and learning.
- We saw learning from complaints. For example, patients on the critical care complex had complained about food being cold. This resulted in staff researching and finding insulated boxes that could maintain the temperature of food. We saw these in use for a patient during our inspection.

Are services at this trust well-led?

Requires improvement

We found that four of the eight core services in the trust required improvement for being well-led. Urgent and emergency services, medical care, critical care and end of life care services were rated good for being well-led.

Most staff but not all staff were aware of the trusts values. However, staff told us that putting patients first was part of the culture. The trust had a vision to deliver the same high quality standard of care for our inpatients across all seven days of the week. There was also a clinical strategy with clear objectives.

We were not assured that serious incidents were effectively managed in maternity. Following our inspection, we were reassured to see that the trust had commissioned an external review of maternity services which would be run by a programme board using project management methodology.

Summary of findings

Both the Board Assurance Framework (BAF) and the corporate risk register were reviewed and although the many of the organisation's key risks were represented, some risks had not been identified at local level.

The executive team were passionate about wanting to see improvements within the organisation and most staff said the executive were visible. In most areas staff morale was good and all staff supported each other and worked as a team. All of the staff we spoke to were proud to work for the trust and felt they did the very best they could for patients.

There was recognition within the trust that the local healthcare system needed to work differently to provide a viable model for delivery of sustainable services to its population. There was work on going to link with partner organisations which was actively progressed by the chief executive officer.

There were examples of public engagement across the trust.

We were assured that appropriate steps had been taken to manage the Fit and Proper Person Test legislation implementation.

Vision and strategy

- The vision for Bedford Hospital was to deliver the same high quality standard of care for inpatients across all seven days of the week. There had been investment of £1.5m into providing seven day services. For example, we saw pharmacy had implemented seven day working in 2015 to provide better care to patients.
- The trusts clinical strategy was approved by the trust board in May 2014. It had four strategic objectives:1. Excellence in quality and safety.2. Effective emergency and ambulatory models. For example, streamlining urgent and emergency care through a single point of access.3. Horizontal integration of pathways with other acute providers for hyper acute services to provide services locally and effectively to meet demand.4. Vertical integration of care with community services.
- In the longer term the strategy was to be an integrated provider, potentially an accountable care organisation. The trust told us that their strategic case had been developed jointly with the CCG and was based on meeting future demand.
- The trust's values were on display within the hospital, which were "valuing people, leadership, respect, honesty and excellence". Most staff but not all, were aware of the trusts values. Staff told us that putting patients first was part of the culture.

Summary of findings

- Bedfordshire was undergoing a health review. Staff said they felt in 'limbo' about the health economy and future of services. Therefore, service strategies and visions were not always clear.

Governance, risk management and quality measurement

- Both the BAF and the corporate risk register were reviewed and although the many of the organisation's key risks were represented, some risks had not been identified at local levels. For example, paediatric staffing levels and the paediatric emergency department environment.
- The executive team demonstrated a good understanding of the risk register and what mitigating actions had been taken to reduce risk. However, we identified risks in the organisation that the executive team were not aware of. The team were quick to respond to our concerns, implementing appropriate actions to reduce patient risk.
- Although all executive team members told us that there was regular challenge within board meetings, qualitative data was not always reflected within the minutes to demonstrate this.
- Mortality and morbidity meetings occurred monthly. The information was reported through the governance structure to ensure early intervention. The trust had an action plan to improve the mortality and morbidity rates. The data was monitored by the divisional team and reported to the trust board.
- We were not assured that serious incidents were effectively managed in maternity. The root cause analysis in relation to individual serious incidents did not always demonstrate a sufficient depth of analysis or learning. Therefore, we were not assured that improvements in practice to prevent reoccurrence had been achieved. We saw some evidence of learning from incidents but were not assured of the ongoing monitoring of changes made and therefore, their sustainability.
- However, we saw guidelines were updated in the light of evidence from investigations. For example, the 2011 guidance for fetal heart rate monitoring was changed in February 2015, in response to the outcome of a serious incident in September 2014. The guidance was amended again in August 2015, in response to the coroner's case held in July 2015.
- Following our inspection, we were reassured to see that the trust had commissioned an external review of maternity services which would be run by a programme board using project management methodology.

Leadership of the trust

Summary of findings

- The executive team were passionate about wanting to see improvements within the organisation, particularly the chief executive director and director of nursing and patient services.
- The executive team had seen some recent changes with two new members joining the trust in the months preceding the inspection. Although both relatively new to the trust, they demonstrated a good understanding of the issues and challenges along with the commitment to address them and were already taking action in some areas.
- The board received development sessions, for example, a solicitor had delivered teaching sessions on the Fit and Proper Person Test and duty of candour. Some board members had mentors in place.
- Most of the service leaders had some longevity working within the trust. However, we found leadership in some clinical areas required strengthening. For example, in maternity.
- Most staff said the executive were visible. Most staff that we spoke with reported to us that they saw their immediate line manager regularly.
- The executive team completed 'in your shoes' days. Where they worked in different areas of the trust with staff, to understand those services better.
- Non-executive directors visited wards before each trust board meeting, to gain better understanding of the trust environment. We were told about examples where non-executive directors had challenged practice as a result of these visits, such as inappropriate equipment storage, and had returned to ward to ensure that improvements had been made.

Culture within the trust

- Staff we spoke with were friendly and welcoming.
- Staff were passionate about their roles and told us they placed a strong emphasis on patient care and experience.
- In most areas staff morale was good, staff supported each other and worked as a team.
- There was a policy in place for the management of equality and diversity. There was good staff understanding of equality and diversity, and meeting patients cultural needs. However, the needs of patients who did not read English were not always met, and there was no work in place for the lesbian, gay, bisexual and transgender staff community.
- All of the staff we spoke to were proud to work for the trust and felt they did the very best they could for patients. All the staff we spoke with said they would be happy for themselves or member of their family to be treated within the trust.

- However, in maternity we found evidence of some discord between the consultant team. Staff expressed concern about the honesty, transparency and suggested a blame culture within the service.

Fit and Proper Persons

- The Fit and Proper Person Test is covered by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which ensures that directors of NHS providers are fit and proper to carry out this important role.
- We were assured that appropriate steps had been taken to manage the 'Fit and Proper persons' legislation implementation. All the senior staff we spoke with were aware of this legislation.
- We checked board members personnel files and found them all to be compliant.

Public engagement

- Over 80 people attended our listening event, where we invited the public to speak with us about Bedford Hospital. They told us that the hospital was part of the community for people living locally. Some attendees told us that they were part of trust organised patient support groups, where they provided peer support for newly diagnosed patients in a condition that they were already diagnosed with. For example, cardiology and neurology conditions.
- Patients were given the opportunity to provide feedback regarding their care and treatment through the Friends and Family Test.
- Social media was utilised to provide the public with information. For example, to advise the public to use appropriate alternatives where available to avoid delays in the emergency department, particularly during times of high demand.
- There were volunteers who undertook various tasks in all the hospitals, including meeting and greeting patients, and helping visitors with directions to their desired destination. There were volunteers in the carers lounge that provided advice and support for carers. Volunteers told us that they had been involved in the development and design of the dementia care wards and were very proud of their achievements.
- Volunteers ran charities on behalf of the trust, The Friends of Bedford Hospital and Bedford Hospitals Charity, to raise funds to buy equipment for all the hospitals in the trust.

- We were told that a user representative sat on the labour ward forum and reviewed guidelines, which was considered best practice
- In addition, the trust had a Patient Council, offers patients and local people the chance to get more actively involved in the hospital and the care and services we provide.
- Patient council members were also invited to participate in the yearly Patient Led Assessments of the Care Environment (PLACE), which assessed the cleanliness, food, privacy and dignity of the patient environment. We saw the PLACE scores for 2015 were better than the national average for cleanliness, food, facilities, and privacy, dignity and wellbeing. The hospital had improved on food for two consecutive years but had fallen on privacy, dignity and wellbeing.

Staff engagement

- The trust took part in the 2014 national staff survey. Fourteen results were in the top 20% of trusts and one was in the bottom 20% of trusts for percentage of staff appraised in the last 12 months. The trust had improved on 22 scores compared to the 2013 survey. For example, 89% of staff were satisfied with the quality of work/patient care they delivered, compared to 80% in 2013.
- The areas where the trust results were better than the England average in 2014 related to:
  - Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
  - Staff agreeing that their role makes a difference
  - Work pressure felt by staff
  - Percentage of staff suffering work related stress in last 12 months
  - Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
  - Percentage of staff reporting errors, incidents or near misses in the past month
  - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
  - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
  - Percentage of staff experiencing physical violence from staff in the last 12 months
  - Percentage of staff feeling pressure in the last three months to attend work when feeling unwell
  - Percentage of staff reporting good communication between senior management and staff
  - Staff job satisfaction score

  - Staff motivation at work
  - Percentage of staff having equality and diversity training in the last 12 months
  - Percentage of staff receiving job-related training, learning or development in last 12 months
  - Percentage of staff having well-structured appraisal in last 12 months
  - Percentage of staff receiving health and safety training in last 12 months
  - Percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice
  - Percentage of staff experiencing physical violence from patient, relatives or the public in the last 12 months
  - Percentage of staff reporting good communication between senior management and staff
  - Staff recommendation of the trust as a place to work
  - Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
  - Percentage of staff experiencing discrimination at work in the last 12 months
  - Overall engagement score
- The areas where the trust results were worse than the England average in 2014 related to:
  - percentage of staff appraised in the last 12 months
- There was a staff engagement plan in place which was created following the 2014 staff survey and evidence of staff events to tackle the main elements that could be improved.
- The trust had a charter for an engaged and healthy workforce which had been in place since October 2015 and aimed to address the health and wellbeing agenda with staff. A separate plan of action was in place and included monthly events for staff.
- There was a whistleblowing policy. It covered all the expected areas, roles and responsibilities and set out the trusts approach to whistleblowing. There was a named non-executive director for staff to contact and “Speak up” credit card sized cards were in place to encourage staff to speak out if something was wrong.

Innovation, improvement and sustainability

- The trust encouraged staff to be innovative. However, some of examples of innovation the trust gave us, were things that had been in place in other healthcare organisations for some time. The executive team acknowledged that in some aspects the trust were ‘catching up’ rather than being innovative.

Summary of findings

- Some executive team members acknowledged that in the past they had been rather operational across the trust to improve culture, particularly regarding safety. Their challenge moving forward was to ensure that senior staff had the skills and knowledge to enable ownership of services at local levels, to ensure changes were sustainable.
- There was recognition that the trust needed to ensure that changes made in response to our concerns were sustainable and that some service models required reviewing, for example paediatrics.
- There was recognition within the trust that the local healthcare system needed to work differently to provide a sustainable model for delivery of sustainable services to its population. There was work on going to link with partner organisations which was being actively progressed by the chief executive officer.

Overview of ratings

Our ratings for Bedford Hospital

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

Our ratings for Bedford Hospital NHS Trust

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

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both outpatients and diagnostic imaging.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital offered Endovascular stent-grafts for popliteal aneurysms, which is an alternative method to open surgery, early indication suggest it is safer and more effective for the patients.
- Image guidance for endoscopic sinus and skull base surgery is used for sino-nasal tumours, revision sinus surgery and disease abutting the optic nerve, carotid artery and skull base. For patients it means safe surgery, closer to home.
- One stop neck lump clinic. This speeds up the diagnosis of head and neck cancer by Tru-Cut biopsy solid tumours and avoids general anaesthetics in most cases, with the potential to speed up treatment.
- The critical care complex had designed and built an attachable portable unit for the end of a patient's bed, to prevent disruption to the patient's care and welfare. The unit was used when patients needed to go for a computerised tomography (CT) scan or a magnetic resonance imaging (MRI).
- A high risk birthing pool pathway was developed and implemented at the beginning of 2015. This meant that women with high risk pregnancies had the opportunity to experience the benefits of water whilst in labour. Midwives who were involved with the development of this project were selected as finalists in the Royal College of Midwives Innovation Awards 2015.
- Dementia facilities met the needs of patients living with dementia. Facilities included a cinema area, activity tables, coloured and picture coded bays and the inclusion of the wanderguard system. Under bed lighting assisted patients to differentiate between beds and flooring at night, and reported falls had decreased since the lighting was implemented.

Areas for improvement

Action the trust MUST take to improve
Action the hospital MUST take to improve

- The trust must ensure patients privacy and dignity is always maintained at all times.
- The trust must ensure all reasonable efforts are made to make sure that discussions about care and treatment only take place where they cannot be overheard.
- The trust must ensure patients always have privacy when they receive treatment or when they used washing facilities.
- The trust must ensure that where a person lacks capacity to make an informed decision or given consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust must improve the incident reporting process to ensure all incidents are reported, including those associated with staffing levels.
- The trust must ensure lessons learnt and actions taken from never events, incidents and complaints are shared across all staff.
- The trust must ensure risk registers reflect the risks within the trust.
- The trust must ensure effective and timely governance oversight of incident management, that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly; including categorisation of risk and harm, particularly in maternity services.
- The trust must ensure patient records are accurate, complete and fit for purpose, including 'do not attempt cardio-pulmonary resuscitation' forms.
- The trust must ensure that systems and processes are in place to ensure the documentation and monitoring of the cleanliness of equipment.
- The trust must ensure that policies are comprehensive.

Outstanding practice and areas for improvement

- The trust must ensure there are the appropriate numbers of qualified paediatric staff in the emergency department and paediatric unit to meet standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing.
- The trust should ensure that were staffing fill rates do not meet trust target, associated risks are identified and mitigated.
- There must be sufficient numbers of staff trained to the expected standard to give life support to paediatric patients.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (1) (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014** **Dignity and respect** 1. Service users must be treated with dignity and respect. 2. Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— A. ensuring the privacy of the service user; **The regulation was not being met because patients privacy and dignity was not always maintained at all times. For example, orthopaedic clinics that took place in 'over flow' areas including the breast clinic, meant that women waiting for their consultation were seated wearing only a gown in an area shared with fully clothed men and women waiting for their orthopaedic appointment.** **All reasonable efforts were not made to make sure that discussions about care and treatment only took place where they could not be overheard. For example, in the emergency department and outpatient department, particularly phlebotomy.** **Patients did not always have privacy when they received treatment or when they used washing facilities. For example, on medical wards.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (1) (2) (3) HSCA 2008 (Regulated Activities) Regulations 2014**

This section is primarily information for the provider

Requirement notices

Need for consent

1. Care and treatment of service users must only be provided with the consent of the relevant person.
2. Paragraph (1) is subject to paragraphs (3) and (4).
3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.

* Mental Capacity Act 2005

The regulation was not being met because staff completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms did not comply with the Mental Capacity Act 2005 and the Code of Practice. Systems were not in place to assess, monitor and mitigate the risks relating to non-compliance with the Mental Capacity Act 2005. Sixteen out of the 32 DNACPR forms we reviewed stated that the patients did not have mental capacity. However, there was no evidence of mental capacity assessments being completed.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014 **Good Governance** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity The regulation was not being met because risks were not always identified and all mitigating actions taken in all areas of the trust, particularly in maternity services.

This section is primarily information for the provider

Requirement notices

Patient records were not always accurately completed, including 'do not attempt cardio-pulmonary resuscitation' forms.

Systems and processes were not always in place to ensure the documentation and monitoring of the cleanliness of equipment. This meant that staff were unable to identify if equipment had been cleaned or not, and therefore, there was a risk to the health and safety of patients using equipment.

Policies were not always comprehensive. For example, the safeguarding children policy and safeguarding adults' policy in place did not make reference to female genital mutilation or to patients admitted with mental health issues.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 **Staffing** 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. The regulation was not being met because nurse staffing arrangements on the paediatric unit and emergency department were not sufficient to meet patient demand. The trust were on occasions understaffed according to their own agreed minimum staffing levels and regularly understaffed according to guidance published by the Royal College of Nursing in 2013. We raised our concerns with the trust who took immediate and appropriate action. However, we need to ensure these actions are sustainable and that staffing levels within the paediatric unit are consistently sufficient to meet patient demand.