Care Quality Commission

Bedford Hospital NHS Trust

Bedford Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement
Chemotherapy	Not sufficient evidence to rate

Summary of findings

Radiotherapy	**Not sufficient evidence to rate** 

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 6.8% but remained worse than the trust target of 1.8%. 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.
- Mortality was slightly worse than 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.
- 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.

Summary of findings

- There were governance processes in pace to provide oversight of incident reporting and management, including categorisation of risk and harm. However, we were not assured that the trust demonstrated a sufficient depth of analysis or learning of incidents, and 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 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.

Summary of findings

- 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.
- 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.

In addition the trust should:

- The trust should ensure all vacancies are recruited to.
- The trust should ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role. Including safeguarding training.
- The trust should ensure staff receive and appraisal to meet the appraisal target of 90% compliance.
- The trust should ensure that all trust policies are up to date and that they are consistently followed by staff.
- The trust should ensure that patient information can be accessed in different languages.
- The trust should ensure all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to.
- The trust should ensure all equipment is in date.
- The trust should ensure facilities for paediatric patients meet national guidelines.
- The trust should ensure facilities for patients with mental health needs meet national guidelines.
- The trust should ensure ligature points are identified and associated risks are mitigated to protect patients from harm.
- The trust should ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum.
- The trust should ensure delays in ambulance handover times are reduced to meet the national targets.
- The trust should ensure that infection control practices are followed by staff.
- The trust should consider reviewing the admission process for elective surgery are in line with national guidance and to ensure patient privacy and dignity is maintained, with assessments completed in rooms with adequate equipment to meet patient needs.
- Ensure that records of all patients diagnosed with sepsis contain the 'Sepsis Six' sticker to alert staff to the patients diagnosis as per national guidance
- The trust should ensure that action plans are in place to improve patient outcomes against national audits.
- The trust should ensure staff that are involved in blood transfusion are up to date with competencies and training.
- The trust should ensure all drug cupboards and medication fridges are in good working order and locked at all times to maintain safe use of drugs.
- The trust should ensure patient records are stored safely.
- The trust should ensure patients belongings are kept safe at all times.
- The trust should ensure that they implement follow up clinics for critical care patients, as recommended in NICE guidance
- The trust should ensure that staff document and monitor the time and decision to admit to the critical care complex.
- The trust should reduce delays experienced by patients in transferring to a ward bed when they no longer required critical care.

Summary of findings

- The trust should ensure that they assess all surgical patients with mortality risk of between 5 and 10% for admission to the critical care complex.
- The trust should ensure that all medicines are within the recommended date.
- The trust should ensure that medicines are stored appropriately.
- The trust should ensure that controlled drugs records are kept up to date and are accurate.
- This trust should review the entrance to the gynaecology ward to ensure the needs of all patients are met.
- The trust should develop a policy on restraint and / or supportive holding and staff should receive training to ensure they understand how to apply the policy.
- The trust should ensure that safeguarding referrals are made in line with trust policy.
- The trust should patient observations are taken and recorded in line with the agreed time frames according to their risk assessment.
- The trust should ensure pain assessments for children are consistently completed.
- The trust should ensure that there a concealment trolley appropriate for bariatric patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated the emergency department within Bedford Hospital to be good. Patient records contained sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage and falls risks, were consistently completed. Evidence based guidance was used within the department and was relevant and up to date. Multidisciplinary working was a strength of the department and relationships with internal and external services helped to avoid unnecessary attendances and facilitated early discharges. The department took part in local and national audits and showed learning from audit outcomes. Patient's feedback was positive about the care they received and we saw good examples of compassionate care within the department. The department was consistently meeting the four hour target, with escalation processes implemented at the earliest opportunity to allow proactive plans to be put in place to assist flow. Leaders showed a good understanding of risk, quality measures and factors required to meet national targets. Working partnerships with internal and external providers were good, allowing holistic patient care. All staff were passionate about providing high quality patient care. The department did not comply with guidance relating to both paediatric and mental health facilities. Following our inspection actions were put in place to address this.

Summary of findings

		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. Mandatory and safeguarding training attendance did not meet the trusts target for both nursing and medical staff.
Medical care (including older people's care)	**Good**	Overall, we rated the service as good for being safe, effective, caring, responsiveness and well led because: There were excellent facilities to provide appropriate care for patients living with dementia. The trust had implemented processes to meet patient needs. However, patient information leaflets were limited to English only, and staff reported using family members for assistance with translation, which was poor practice. Medical patients in outlying wards were effectively managed and a policy was in place. Bed management meetings were held three times a day to discuss and prioritise bed capacity and patient flow issues. Discharge coordinators and the complex discharge team helped to facilitate appropriated patient discharge. Wards were generally clean and had effective systems in place to minimise the risk of infections. Referral to treatment performance was in line with national targets. Incidents were reported and staff were generally aware of what preventative actions could reduce the risk of avoidable harm to patients. Although there was a high level of nursing staffing vacancies within some teams and reliance on agency staff,

Summary of findings

staffing levels did generally meet patient needs at the time of our inspection. Medical staffing was in line was national guidance.
There was some evidence of progress to providing seven day a week services. Mortality ratios were similar to those of similar trusts and the service had systems in place to review mortality rates. Care was provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Multidisciplinary team working was generally effective. Pain relief, was assessed appropriately and patients said that they received pain relief medication when they required it.
The medical care service was generally well-led at a ward level, with evidence of effective communication within ward staff teams. The leadership and culture promoted the delivery of high quality person-centred care as governance and risk management systems were in place in the service. The visibility and relationship with the middle and senior management team was generally clear for junior staff. All staff were committed to delivering good, safe and compassionate care.
Generally, patients received compassionate care and their privacy and dignity were maintained.
However, we found that:
Not all essential equipment had been checked as required by trust procedures. Some wards were cluttered with insufficient storage for equipment. Appropriate systems were in not always in place for the prescription, storage, administration and recording of medicines.
Patients did not always have good outcomes as they did not always

Summary of findings

receive effective care and treatment that met their needs. Performance and outcomes did not meet trust targets in some areas.
Most staff said they were supported effectively, but there were no regular formal supervisions with managers. Appraisal rates did not meet trust target.

Surgery

Requires improvement

We rated surgery services as good for effective, caring and responsive, and requires improvement for safe and well-led because:
The pre-operative screening process did not ensure that all patients 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.
There was confusion over the management of positive Methicillin-resistant Staphylococcus Aureus (MRSA) results following MRSA screening taken at pre-operative assessments and staff did not always follow the trusts infection control policy.
The policy for anticoagulation advice for patients was out of date on September 2014. There was no clear guidance for the management of all patients on anticoagulation who required surgery. We saw this impact on patient care. We raised this with the trust that approved new guidance in January 2016.
There was a culture of incident reporting, but staff said they did not always receive feedback on incidents

Summary of findings

submitted. Staff were unaware of never events and serious incidents that had recently occurred and no learning had been shared.

Medicines were not always stored safely and securely to prevent theft, damage or misuse.

There was support for patients with a learning disability and reasonable adjustments were made to the service to accommodate patients with individual needs. Information leaflets and consent forms were not available in other languages. An interpreting service was available.

Medical staffing levels were appropriate and there was good emergency cover. Consultant-led, seven-day services had been developed and were embedded into the service. There was a high number of nursing vacancies; agency and bank staff were used to cover vacant shifts.

The environment was visibly clean.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Patient care records were appropriately completed with sufficient detail.

Multidisciplinary working was evident.

Appraisal levels did not meet the required target. Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs).

Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients treated with dignity and respect.

Surgical services were supported by dedicated senior staff, who were visible on the wards and theatre areas and staff appreciated this support. There

Summary of findings

was variable awareness amongst staff of the hospitals values. Staff were unaware of national audits undertaken within the hospital or of patients' outcomes relating to national audits.

Critical care

Good

Overall, we rated the critical care services as good.

We judged the safety of critical care services as good. Staff on the critical care complex (CCC) knew how to use the trust's online incident reporting system and did so. All serious incidents were analysed and discussed at weekly meetings.

The environment was visibly clean and staff followed the trust policy on infection control. Medical and nurse staffing levels was appropriate and there was good emergency cover.

There was good compliance with regard to mandatory training.

The critical care outreach (CCO) team provided 24-hour support to the risk of deteriorating patients outside of the CCC. The CCC assessed and responded to patient risk such as the review of patients admitted.

Critical care services were effective. The treatment and care provided followed current evidence-based guidelines. The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC). Data from audits showed there were good outcomes for patients treated in the critical care services.

Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We found critical care services to be caring. Staff built up trusting relationships with patients and their relatives by working in an open, honest

and supportive way. Patients received good care, compassion, dignity and respect. We observed patients received good emotional support.

We rated responsive as requires improvement. Flow out of the CCC posed problems and many patients' discharge exceeded the recommended discharge time of four hours. ICNARC dated from March to June 2015 showed that the CCC had more delayed discharges (more than four hours) than similar intensive care units. Due to the delay in discharges, the CCC often breached the same sex guidelines. They completed the national forms in relation to sex breaches but did not complete an incident report for sex breaches. However, monitoring data demonstrated that the trust had no issues with flow into the department. Patients discharged to the ward had follow-up support from the CCO team. The CCC did not have psychological support for patients, relatives or staff. This had been identified as a recommendation by the Guidelines for the Provision of Intensive Care Services (GPICS) standard report for 2015. Patients discharged from CCC did not have access to follow-up clinics. This contravened NICE guidance 83. Senior staff described the business plan they wished to implement regarding follow-up clinics.

The records did not identify patient documentation regarding the time and decision to admit to CCC. Staff confirmed they did not record the data. This meant the unit did not know if they were meeting the four-hour target of the decision to admit. However, the trust responded following feedback and amended its electronic patient record system to record this information.

Summary of findings

Staff understood the procedures regarding complaints. However, they said that any complaint received would firstly be resolved locally. If a local resolution was not achievable, the trust's complaints service was available to patients and their families/ representatives. This meant that the outcomes, themes or lessons learnt were not cascaded to staff on all complaints received.
Patients' relatives said they were involved and kept informed. There was good awareness of the needs of people living with dementia, learning disability or mental health needs. They had access to the allied mental health professional (AMHP) and liaised closely with them.
We rated the critical care service as good for well-led. A clear vision for the future of the critical care service team was not evident. Senior management said there was not a strategy for critical care and wished to implement the trust wide strategy prior to reviewing the CCC's strategy.
The critical care bi-monthly minutes for mortality and morbidity did not have a systematic review of all mortality and morbidity within the unit. There were no actions identified with no time scales attached.
Senior staff and clinicians attended critical care governance meetings. Discussed at governance meetings were the risks to the service and significant events in other areas of the hospital. There were identified actions and who would be responsible for them.
Staff said the recent reconfiguration of the service had improved morale. The staff survey reflected this.

Maternity and gynaecology — **Requires improvement** 

We rated maternity and gynaecology services as requiring improvement. We

Summary of findings

found the service requiring improvement for being safe, responsive and well-led, and good for being effective and caring.

We found that the clinical governance system was not robust. Senior staff within the maternity unit did not manage incidents in a timely manner and in accordance with best practice. We reviewed the trusts serious incident policy and maternity risk policies and found that the staff in the maternity unit were overall following the trust policy but there were gaps and weaknesses in the policy. 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 incident investigation reports to included learning and conflict of interest.

In response to a cluster of serious incidents in maternity, the trust was reviewing all intrapartum deaths and stillbirths in the past year and had commissioned an external review of the maternity service.

Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Patients told us they had a named midwife. The ratio of clinical midwives to births was one midwife to 30 women which was worse than the national target of one to twenty eight women.

The trust provided evidence of one-to-one care during labour which is recommended by the Department of Health. Women told us they felt well informed and were able to ask staff if they were not sure about something. Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology wards.

Services for children and young people

Requires improvement

Services for children and young people at Bedford Hospital were judged to require improvement for safe, effective and for being well-led, and good for caring and responsive.

Incidents were not always reported and those reported were not always investigated in a timely manner. We noted that actions recorded did not always address the issues raised, in particular for staffing incidents and there was a lack of shared learning.

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. Nursing staffing arrangements on the neonatal unit were adequate to meet requirements, most of the time.

Completion of mandatory training within the service was not compliant with the trust's target of 90%, and staff had not completed other recommended training for example Advanced Paediatric Life Support. Following our inspection the trust implemented an action plan to address this.

Most staff had completed safeguarding training and there were suitable procedures in place for reporting safeguarding concerns. However, the trust policy was not always followed.

Patient dependency levels were not always assessed and observations were not always completed within agreed

Summary of findings

timeframes, as per the patient's risk assessment for patients on the paediatric unit. There were also inadequate arrangements in place to care for patients with mental health needs.

The environment was observed to be visibly clean during our inspection, although the units' own audits identified some areas of non-compliance.

Some equipment and medicines were out of date and relevant checks had not always been undertaken or not recorded. Records were suitably stored and most contained adequate detail.

A clinical audit plan had been developed for 2014/15 and 2015/16. However a proportion of audits had not been completed, and agreed actions and recommendations did not always address the issues identified.

Policies and care pathways relating to paediatrics and neonates were up to date and had considered national guidance as appropriate.

The service used a dashboard to monitor performance, although this was difficult to read 'at a glance' and not all relevant data had been included, raw data for some outcomes were provided.

All of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff listened to them and were compassionate; and this was supported by our observations.

We found evidence of multidisciplinary support being facilitated throughout children's services and patient's individual needs were met most of the time, although some improvement was required to support patients with learning difficulties.

There were governance arrangements in place, the paediatric and neonatal

unit quality group was the main meeting for paediatrics and neonates. Meetings were minuted although the level of detail was variable.
The risk register failed to consider a number of risks, including some we identified during inspection, for example staffing shortages.
Leadership worked well and staff felt listened to most of the time, but that management failed to respond to some issues raised in relation to staffing shortages.

End of life care

Good

Overall, we rated the service as good for safety, responsiveness, caring and well led. We rated effectiveness as requires improvement.
The trust had in place a replacement for the Liverpool Care Pathway (LCP) called Bedford Hospital care of the dying patient, supporting care in the last hours or days of life (C of D). The care plan provided guidance for staff to deliver end of life care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Implementation of the C of D care plan had been slow but the SPCT were monitoring implementation of the C of D care plan and had completed actions to improve implementation across the service.
The SPCT had begun a process to monitor the quality of the service effectively. For example, we saw the SPCT had carried out a retrospective medical case review of all ward deaths for a week in February 2015. The notes were reviewed against the One Chance To Get It Right standards The information from this audit was fed into and monitored at the SPCT meeting, end of life steering group, mortality board and to the hospital management board.

Summary of findings

Patients we spoke with were very happy with the care that had been provided to them. Relatives we spoke with were happy with the care that their relatives had received

The trust, supported by the partnership for excellence in palliative support (PEPS) team (commissioned by Bedfordshire Clinical Commissioning Group (CCG) and managed by a local hospice) and the local hospice, planned and delivered services in a way that met the needs of the local population.

The discharge planning process was supported by the PEPS team which enabled patients' discharge was arranged appropriately.

Overall, we saw that leadership was good. Local leadership was knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them.

The trust had both an executive director and a non-executive director who provided representation of end of life care at board level.

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.

Summary of findings

The trust took part in the National Care of the Dying Adult of Hospitals (NCADH) in 2013 to 2014 and achieved one out of seven of the organisational key performance indicators (KPIs). The trust scored lower than the England average of 9/10 clinical KPIs. The trust did however, score substantially better than the England average for the clinical KPI about the percentage of cases receiving a review of care after death. The trust had an action plan in place to improve some aspects of end of life care.

Outpatients and diagnostic imaging

Requires improvement

Overall we rated outpatients and diagnostic imaging services as requires improvement.
Safety concerns were not consistently identified or addressed quickly enough and necessary improvements were not always made when things went wrong. Infection control procedures were not always followed and clinic environments were not all fit for purpose. Staff working in clinics attended by children and young people did not have adequate training in safeguarding children, and staff were not all up to date with mandatory training. There were staffing shortages across clinical and support staff in many outpatient and diagnostic services. Very few services were provided seven days a week.
Medical records were maintained accurately and securely, and there was an effective records tracking and location system. Clinical areas were generally clean and well-organised.
Staff used national and professional guidance when carrying out assessment, diagnosis and treatment. Staff had good opportunities for professional development but the outpatients and diagnostic services did

not provide all staff with an annual performance appraisal. In some areas this fell well below the trust target of 90%.
Staff treated patients and their relatives with dignity and respect. Patients were given sufficient information to make decisions about their treatment and felt they were well informed. However, services did not always meet people's needs and the needs of the local population were not fully identified or taken into account. The environment did not meet the needs of people with dementia or a visual impairment. Despite serving a multi-cultural population, outpatient and diagnostic services did not provide patient information in formats other than written English. There was no easily accessible complaints system and staff had a poor understanding of managing complaints. Patient feedback was limited.
Access to services was well managed. Waiting times for appointments met the national standards and patients were able to attend appointments swiftly, through an effective booking system.
Overall staff were positive about working in their teams and felt well supported by managers. However, the leadership, governance and culture did not always support the delivery of high quality assessment and treatment. There was no clear vision or strategy for the services. Governance and risk management systems did not consistently operate effectively and risks were not always managed in a timely way.

Chemotherapy	**Not sufficient evidence to rate**	
Radiotherapy	**Not sufficient evidence to rate**	

Bedford Hospital

Detailed findings

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

Detailed findings

Contents

Background to Bedford Hospital

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. The hospital provides a full range of district general hospital services.

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)
- Surgery
- 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

Detailed findings

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?
- 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.

Facts and data about Bedford Hospital

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

Detailed findings

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.

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.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	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	Not rated	Good	Good	Requires improvement	Requires improvement
Chemotherapy	N/A	N/A	N/A	N/A	N/A	Not rated
Radiotherapy	N/A	N/A	N/A	N/A	N/A	Not rated
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Bedford Hospital NHS Trust provides a 24 hour service, seven days a week to the local population.

The department consists of a waiting area, 10 minor cubicles, seven majors cubicles and four resuscitation bays. There is an observation ward within the ED that allows up to 10 patients to be cared for until they can be discharged or admitted following return of diagnostic results.

The hospital did not have a separate children's ED; a second waiting area was used for paediatric patients within the adult ED.

The ED saw 67,139 patients between April 2014 and March 2015, of these patients 13,258 were aged 16 and below, accounting for 19.8% of attendances.

Within the same time period around 25% of attendances resulted in an admission. Including patients requiring ambulatory emergency care and patients admitted for up to six hours to the department's observation unit.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance only entrance. Patients, who self-presented to the department, reported to a streaming nurse who would direct them to the most appropriate clinical area where they would then be booked in by a receptionist.

Patients who attended the ED should be expected to be assessed and admitted, transferred or discharged within a four hour period in line with the national target.

During our inspection, we visited all clinical areas and Folwell observation ward. We spoke with 28 patients, 32 staff, and 11 people visiting relatives. We also looked at the care plans and associated records of 34 people. We held focus groups with nursing, medical staff and ancillary staff, as well as speaking to senior doctors and nurses.

Urgent and emergency services

Summary of findings

We rated the emergency department within Bedford Hospital to be good.

Patient records contained sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage and falls risks, were consistently completed.

Evidence based guidance was used within the department and was relevant and up to date.

Multidisciplinary working was a strength of the department and relationships with internal and external services helped to avoid unnecessary attendances and facilitated early discharges.

The department took part in local and national audits and showed learning from audit outcomes.

Patient's feedback was positive about the care they received and we saw good examples of compassionate care within the department.

The department was consistently meeting the four hour target, with escalation processes implemented at the earliest opportunity to allow proactive plans to be put in place to assist flow.

Leaders showed a good understanding of risk, quality measures and factors required to meet national targets. Working partnerships with internal and external providers were good, allowing holistic patient care.

All staff were passionate about providing high quality patient care.

The department did not comply with guidance relating to both paediatric and mental health facilities. Following our inspection actions were put in place to address this.

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.

Mandatory and safeguarding training attendance did not meet the trusts target for both nursing and medical staff.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement.

Mandatory and safeguarding training attendance did not meet the trust target and there were no action plans in place to address this.

The department did not comply with guidance relating to both paediatric and mental health facilities. This was escalated to the trust and following our inspection actions were put in place to address this.

Infection control practices were not always followed in line with trust policy.

Medicines and their guidance for constitution were not always in date. Controlled drugs records were not completed in accordance with regulations.

Incidents were reported appropriately and lessons learnt resulting from them were shared amongst staff regularly.

Staff had a good knowledge of duty of candour regulations and how they were relevant to their role.

Equipment was well maintained and suitable for use throughout the department.

Patient records contained sufficient detail to ensure all aspects of their care was clear. Risk assessments, including skin damage and falls risks, were consistently completed.

A major incident plan and policy was in place and staff within the ED were aware of their role and responsibilities within this.

Incidents

- There had been no Never Events reported between August 2014 and July 2015 within the ED. 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.

- The ED reported four serious incidents between August 2014 and July 2015: one was a diagnostic incident, one was a communication issue, one was an investigation into a cardiac arrest and one was an investigation into a paediatric death in the department.
- An electronic system was used for reporting untoward incidents. All nursing and medical staff within the ED knew how to access and use this system. Nursing and medical staff told us they received feedback from incidents they reported, but that this occasionally took long periods of time.
- Learning from incidents was fed back to staff in a variety of ways, including via newsletters, during staff meetings and within daily departmental handovers. We saw evidence of this learning shared within three staff newsletters of incidents themes and learning points.
- Between January and August 2015, 213 incidents had been reported by staff.
- Failure to follow guidance or protocols made up the highest proportion of incidents reported (50 incidents), pressure ulcers made up the next highest proportion (24 incidents); however 21 of these incidents were reported on admissions to hospital and not acquired whilst in the department. The next most reported incidents were in relation to patient falls/ accidents (19 incidents), failure to treat (20 incidents) and communication incidents (18 incidents). Senior staff undertook a review of incident investigations to ensure they thoroughly completed and to protect patients from repeated similar incidents by establishing any lessons to be learnt. Every incident reporting form was reviewed by the senior clinical team which gave them an understanding of the issues within the department.
- ED mortality was discussed during the monthly Acute Medicine Quality Group Meeting. Within the most recent minutes it stated that the group recognised that the division had to strengthen the mortality process after the initial mortality review and discussed the possibility of setting up a meeting just for mortality. This was to be discussed at the next meeting.
- 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.
- Nursing and medical staff we spoke with in the ED were aware of duty of candour. Staff told us they knew the importance of being open and honest with patients if something went wrong.
- We saw evidence from previous incident reports that patients were informed by the trust in a timely way if something had gone wrong relating to their care.
- We saw posters around the ED which explained to staff how duty of candour was relevant to their role.

Safety Thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter urinary tract infections and falls.
- There had been no reported category 2, 3 or 4 pressure ulcers or catheter related urinary tract infections within emergency or urgent care between July 2014 and July 2015.
- Three falls with harm had been reported within the same time period.

Cleanliness, infection control and hygiene

- Hand hygiene audits were carried out monthly. Compliance between April and August 2015 was an average of 96% which was better than the target of 95%. If any specific staff groups were not compliant with hand hygiene this was documented and any actions required identified, however this was not a regular occurrence due to compliance being high.
- All staff groups carried out regular hand hygiene practices during our inspection, including hand washing and using alcohol gel between patient contacts.
- Personal protective equipment (PPE) was available throughout all areas of the department but was not utilised in accordance with the trust's infection control policy. We saw five occasions where gloves and aprons were not utilised appropriately to protect staff and patients from infection control risks.
- Some items of disposable equipment were not stored within their sterile packaging, this included laryngoscope blades and suction catheters. We raised

this with the senior leadership team and all items were stored in line with manufacturer's guidance within 24 hours. Prior to our inspection the practice of ensuring items remained in sterile packaging was not within the trusts infection control policy. Post inspection we were provided with evidence to show that this practice was now reflected within the trusts policy and intermittent spot checks were to be carried out to assess and ensure compliance.

- Sharps management across the ED was not in line with hospital policy. Eight sharp bins observed did not have temporary closures in place and two of these were over the fill limit. This posed a risk of needle stick injury and cross-contamination to patients and staff.
- Side rooms with doors were available for patients requiring isolation, signs were visible to show staff and visitors when this was the case. Medical and nursing staff could explain how isolation procedures were followed within the department and which patients would require isolated care.
- During our inspection the department was not always visibly clean, floors appeared dirty and dust was present on surfaces within store rooms and kitchens.
- Environmental audits were managed by the trust's infection prevention and control team; audits were carried out annually within clinical areas, with the most recent showing 77% compliance. Cleaning standards, based on the cleaning schedule for wards and clinical areas were audited on a four-weekly cycle. We saw necessary improvement actions documented following cleaning standard audits and infection control audits.
- Domestic staff completed cleaning schedules and documented areas where they had discovered problems, including split flooring and increased dirt build up, and actions they had taken to rectify them.
- Although equipment appeared clean during our inspection there was nothing in place to inform staff using the equipment that it had been cleaned prior to its use.
- Infection control training had been attended by 72% of nursing staff and 52% of medical staff; this did not meet the trusts target of 90%.
- Infection prevention and control advice leaflets were available to patients and visitors within all areas of the ED. This advised patients how they could help prevent infection from spreading.

Environment and equipment

- The department did not have a secure paediatric area. Cubicles used for paediatric patients could be accessed from the rest of the hospital. This is not in line with Royal College of Paediatrics and Child Health guidance that states children's area should be secure and zoned off to protect children.
- We escalated this to the executive team who put an action plan in place to minimise risk. Within the action plan the trust intend to place secure doors between the children's area and the adult area, until this work is carried out the doors leading to the main hospital have had a key coded lock placed on them to ensure only staff can access the area. The trust informed us at the end of January 2016 that the doors had been put in place.
- The children's waiting area had a large window facing the outside of the ED which makes it visible by other patients and visitors. Health Building Note 15-01 states that children's waiting areas should allow observation by staff but not allow patients or visitors within the adult area to view the children waiting.
- Within the majors area there were no dedicated paediatric rooms or cubicles, staff told us that one specific room opposite the nursing station was generally used for paediatric patients and contained all of the necessary resuscitation equipment. However throughout the duration of our inspection we saw six adult patients use this room. This meant if a critically unwell child attended the department that someone would need to obtain the equipment from this room.
- There was no dedicated mental health room within the department. Patients with mental health conditions were placed in either a cubicle or within the relative's room. Neither of these areas were compliant with Royal College of Emergency Medicine (RCEM) guidance that requires assessment rooms to have an alarm system, two doors and no ligature points or object that can be used as missiles.
- The lack of risk assessment of the relative's room was raised with the trust that ensured an assessment was carried out. An action plan was put in to place to reduce risk to patients and staff including personal panic alarms, removal of ligature points and constant observation of patients with mental health conditions in the department.
- Staff understood the requirements but stated a dedicated mental health room had not been created due to the size and layout of the department. Senior

managers explained that if plans for a new department went ahead they intended to design a room suitable for patients with mental health conditions that was compliant with guidance.

- The majority of environmental concerns were directly related to the limited space within the department and also the layout that was designed when the department was created. Staff felt that with extra space and a more practical layout all of the environmental problems could be easily resolved and create a safer space for patients.
- The computerised tomography (CT) scanning suite was a long distance from the ED, staff told us this sometimes caused a delay in patients going for their scan as they had to ensure enough qualified staff chaperoned the patient across the hospital and remained with them for the duration. We were told it meant that the department was then short staffed for sometimes a prolonged period due to the distance.
- Daily checks of resuscitation equipment occurred within the ED, record books were not always completed in line with trust policy, with five days in November 2015 not having checks documented. Resuscitation trolleys were located in central areas and available should they be required.
- All equipment had received portable appliance testing (PAT) to ensure they were safe for use in accordance with trust policy.
- We found some items of CBRN equipment were out of date, including a tracheostomy set that expired in 2008 and a chest drain that expired in 2012. We raised this with the nurse in charge of the department who rectified this immediately. Following our inspection, the trust implemented a monthly check of consumables.

Medicines

- There was no routine clinical pharmacy input to the ED but nursing staff told us that members of the pharmacy team were available by telephone if needed, including out of hours. A stock top up service was provided.
- We found that the temperature of the medicines storage areas was not monitored or recorded. The temperature of the refrigerator in the resuscitation area had been recorded as being outside the recommended range for the safe storage of medicines. Nursing staff could not tell us what action had been taken. We were therefore not assured that medicines were always stored in a way which maintained their quality.
- Medicines, including controlled drugs (medicines which are controlled under the Misuse of Drugs legislation), were stored securely. Controlled drugs records were not fully completed in accordance with the regulations. We saw examples where the quantity used had not been recorded, and errors in the register had not been corrected in line with national guidance. The emergency department had not been included in recent controlled drugs audits so these issues had not been raised in order for improvements to be made.
- The minutes of a sisters meeting in December 2015 recorded that documentation within the controlled drug books was not always consistent and required improvement. We did not see evidence of actions related to improving this and also found these inconsistent documentation during our inspection.
- Medicines within the major incident store were not in date, this included adrenaline and propofol that expired in 2014. We raised this with senior staff and these medicines were removed and returned to pharmacy whilst we were on site.
- Medicines for children were provided in liquid form to aid administration.
- Guidance relating to the formulation and delivery of intravenous (IV) medicines did not contain review dates. This meant we were unable to see if guidance had been reviewed recently or was in line with most recent local guidance.
- We observed staff preparing and administering IV medicines, this was in accordance with national guidance.
- All records we reviewed contained patient's allergy status and this was confirmed with patients.
- Local microbiology protocols were in place for the administration and prescription of antibiotics, staff accessed these protocols via the trust intranet.
- A pharmacy technician attended the department every other day to check stock and provide top ups of medicines where required.
- All Emergency Nurse Practitioners (ENPs) within the department were independent prescribers; this meant that patients could have medications, such as antibiotics and pain relief, prescribed without seeing a doctor.
- The department were beginning to introduce the ability for staff to administer simple analgesia under patient group directives (PDGs). PGDs provide a framework that allows some registered health professionals to

administer a specified medicine to patients without them having to see a doctor. This had not been fully implemented during our inspection and staff were in progress of having competency checks completed.
- Since January 2015 there were 10 reported incidents relating to medicines, there were no themes to these incidents and all were actioned appropriately with patients being informed if they had received incorrect dosages or incorrect medicines.

Records

- Records within the ED were paper based, with the addition of diagnostics and previous attendances being computerised.
- Records for current patients within the department were easily located in numerical trays.
- We reviewed 34 patient records during our inspection and found them to be legible and with correct patient details. All records were stored in a manner that maintained confidentiality.
- Records audits were not conducted within the department.

Safeguarding

- All medical and nursing staff with the ED were required to attend adult safeguarding training and level 3 children safeguarding training.
- Safeguarding training was provided during induction for medical staff. Nursing staff were required to carry out yearly safeguarding updates. Attendance rates for both adult and children safeguarding were not meeting the trusts target of 90%. 84% of nursing staff and 64% of medical staff had attended level 3 adult safeguarding training and 88% of staff had attended level 3 children safeguarding training. We saw that low attendance of safeguarding training was discussed during departmental meetings and senior leaders were implementing actions to ensure staff attended at the earliest opportunity.
- All nursing and medical staff we spoke with showed a comprehensive understanding of identifying and reporting any safeguarding concerns. We saw examples of appropriate safeguarding referrals made.
- We asked a senior clinical manager to show us how to make a safeguarding referral, they were unable to do this and stated they were unfamiliar with the process.
- All paediatric attendance notes were reviewed by a health visitor liaison. This ensured that there was a clear oversight safeguarding of children and that any safeguarding concerns missed by clinical staff were identified during this secondary review.
- Paediatric patients safeguarding status was assessed on their arrival to the department. An alert system was in place to identify children known to social services or if there had been any previous safeguarding concerns. Reception and nursing staff all knew the symbol that identified these patients.
- Children were checked against the child protection, missing children and unborn registers. If there were any concerns about the safeguarding of a child, the registrar or consultant would assess the child rather than a junior doctor.

Mandatory training

- Mandatory training included topics such as information governance, fire safety, conflict resolution and infection control. We were provided with data to show how many nursing and medical staff had attended the necessary mandatory training for their role. We saw that the majority of topics did not meet the trusts target of 90% attendance for nursing staff, with information governance training having 78% attendance within the last 12 months. The only topic that met the 90% target was Ebola training of which 94% of nursing staff had completed. No topics met the trusts target of 90% attendance for medical staff, with equality and diversity having 52% attendance and moving and handling having 44% attendance.
- Departmental meeting minutes identified that mandatory training was not meeting the trust targets and actions were put in to place to ensure all staff were booked onto a course. We also saw within newsletters that staff were reminded to book places on course to ensure they were compliant within all areas.
- 27 members of staff across both nursing and medical teams were trained in intermediate paediatric life support (PILS), this equated to 32% of staff. Seven of the ED medical team had advanced paediatric life support training (32% of all medical staff).

Assessing and responding to patient risk

- Walk-in patients were met by a streaming nurse who carried out an initial brief assessment prior to the patient booking in. This service had only been in place for a few days during our inspection and was only running between 10am and 9pm.
- The three nurses who cover this role were ENPs who had triage competencies and experience.
- The streaming process involved the nurse obtaining basic patient details including their name, address and date of birth, along with a brief history of their presenting complaint and a pain score if required. A form was completed containing this information and handed to the patient to take to reception and book in. Patients would then wait to see a further triage nurse who would take a more in depth history and observations.
- If patients had any significant symptoms including chest pain, stroke symptoms or severe shortness of breath they would be taken directly to the majors area of the department for further assessment.
- During hours where a streaming nurse was not in place patients would book in at reception and remain in the waiting area until seen by a triage nurse.
- The average time to triage between July 2015 and January 2016 was nine minutes, with two peaks in the month of November and December 2015 where the averages of 12 and 19 minutes to triage respectively.
- Patients under the age of 16 who were deemed to require minor treatment were sent directly to the children waiting area following streaming, those who required majors or resuscitation were taken directly to majors as per adult patients.
- Patients arriving by ambulance would directly enter the majors area where the ambulance crew would hand over to the nurse in charge, or patients would go directly into resuscitation if the patient had a life threatening condition.
- Ambulance staff we spoke with told us they sometimes had delays in handing over patients and had to queue in the ambulance entrance corridor. During our inspection we did not witness any ambulance delays or queuing of patients. We were told that observations and basic interventions were carried out on patients by the ambulance staff whilst waiting and that a senior doctor and the nurse in charge would regularly review patients waiting in the corridor to ensure they had not deteriorated. We saw no evidence of impact of this waiting on patients and no incidents had been reported in relation to patients deteriorating in the corridor.
- Over the winter period November 2014 to March 2015, 569 ambulance hand-overs were delayed for over 30 minutes (3.8% of ambulance attendances), 218 of these were delayed for over 60 minutes (1.4% of ambulance attendances). The department was in the middle 50% of all trusts in England for numbers of delayed ambulance handovers.
- The average time from ambulance arrival to clinical assessment between June and December 2015 had been two minutes. Clinical assessments of patients bought in by ambulance could occur prior to them being handed over to staff in the ED.
- A hospital ambulance liaison officer (HALO) was in place to monitor and manage any ambulance delays. The HALO informed us that if any patients deteriorated whilst waiting for a cubicle this would be directly escalated to the nurse in charge of the department.
- The ED used the National Early Warning Score (NEWS) to assess deteriorating patients and we saw evidence of its use on the observation charts attached to ED records. We saw any change in a patients NEWS was escalated to medical staff for review.
- If an increase in patient demand affected patient safety this was escalated as per the escalation policy. Senior nursing staff told us they were confident following the escalation process and were supported by senior managers when this occurred.
- We saw that pressure area checks were carried out on the majority of patients and documented within their records. A daily repositioning chart was available for use with patients who were at risk of skin damage; however we did not see any patients remaining in the department for long enough to require one of the charts to be completed.
- Falls risk assessments were completed for the majority of patients and documented in their records. Staff told us that if a patient was high risk they would be placed in a cubicle that could be observed from the nursing station to reduce the risk of a fall.
- We reviewed eight patient records that had a diagnosis of sepsis. We saw that only three patients had been administered antibiotics within one hour, and only one

patient had urine output documented. This did not meet national guidance. Improving time from arrival to antibiotics was noted as an intended improvement following the RCEM audit.

- Folwell observation unit formed part of the ED. The unit contained two trolleys and a number of chairs. A standard operating procedure (SOP) was in place to advise staff which patients could be cared for in this area. Patients who were placed in this area included those awaiting transport, requiring IV fluids, awaiting blood results or those requiring observation for less than six hours prior to discharge. All patients cared for on Folwell were required to be ambulatory. This area was staffed by a nurse and a healthcare assistance (HCA) at all times that cared for a maximum of 10 patients at any one time to ensure that all patients could be managed safely.

Nursing staffing

- The department had 13.04 whole time equivalent (WTE) band 5 nurse vacancies (45.3%), 2.73 WTE nurse team manager vacancies (33.3%) and 0.5 WTE team manager vacancies (33.3%). However the department had in excess of their necessary WTE for pre-registration practitioners, high level clinical support workers and team leaders.
- Three of the nurses within the department were paediatric trained, acute support was provided by Riverbank paediatric ward if necessary. We saw one incident report relating to a shift where there was no paediatric nurse on duty and it had not been able to be covered by agency or bank staff, in this instance a nurse was provided by Riverbank ward for the shift.
- 52% of nursing staff within the ED had completed paediatric intermediate life support (PILS) training.
- On average between August and November 2015 there were 1.2 WTE vacant nursing shifts per day, this was a mixture of both adult and paediatric nurses. These vacant shifts were filled with agency or bank staff.
- We spoke with three agency nurses during our inspection, all of which had previously worked shifts in the department. They told us that they had an induction prior to commencing their first shift within the ED and were aware of policies and procedures within the department. Senior managers told us that the majority of agency and bank staff had been working within the ED for a long period of time and were very familiar with the department.
- Staffing vacancies for both adult and paediatric nurses were reflected accordingly within the departments risk register.

Medical staffing

- Consultant cover was provided in the 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.
- Overnight cover was provided by three specialist registrars and four junior doctors.
- Handover took place twice a day and we observed a medical handover during our inspection. We found it was detailed and gave appropriate information to incoming doctors to be able to meet patients' needs.
- Most ED locum cover was provided internally by those familiar with the hospital and department. If a new locum was working in the department they would be given a file on arrival containing necessary information about the department and a smartcard to use the computer system.
- The department had 29 WTE medical staff, there were two grades that had vacancies, which were 1 WTE specialist registrar and 2 WTE specialty doctor.
- The department did not see over 16,000 paediatric patients per year so was not required to have a consultant with sub-specialist training in paediatric emergency medicine in line with the 2012 Intercollegiate Emergency Standards.

Major incident awareness and training

- The trust's major incident plan had been recently reviewed. A copy of this policy was available within the ED. This policy clearly outlined the role the ED would play should there be a major incident.
- We asked how many staff had completed chemical biological, radiological and nuclear (CBRN) emergencies training and were told that this data was unavailable as a previous training provider could no longer carryout the training. A new provider had been sought and training would recommence within the next three months.
- There was a policy in place for treating patients with Ebola and Middle East respiratory syndrome

coronavirus (MERS–Cov). Staff were able to tell us their responsibilities in the event of a patient with these conditions arriving. They were supported by an up to date policy.

- A room had been created to care for patients who were suspected to have Ebola. Staff we spoke with had a good understanding of how this room was to be used and which areas should be used for patient care and decontamination.
- We reviewed the major incident equipment which was stored in a cupboard. It was clearly organised and well set out allowing staff easy access to everything they required.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good.

The ED used a number of evidence based protocols that followed National Institute for Health and Care Excellence (NICE) guidelines and the Royal College for Emergency Medicine's (RCEM's) clinical standards for emergency departments for the management of such conditions as sepsis and septic shock.

Multidisciplinary working was a strength of the department and relationships with internal and external services helped to avoid unnecessary attendances and facilitated early discharges.

The department took part in local and national audits and showed learning from audit outcomes.

Staff demonstrated a good knowledge of the key elements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards and understood how it related to patient care.

The trust's unplanned re-attendance rate within seven days was generally better than the England average but was not meeting the national target.

Evidence-based care and treatment

- The 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.
- Results from the 2013 Severe Sepsis and Septic Shock audit showed good performance compared to all trusts in the UK. The trust's audit scores were in the top 25% of all trusts for four (33%) standards, and in the bottom 25% for one (8%) standard. The trust's scores for the remaining seven standards were in the middle 50% of all trusts. The trust only achieved one of twelve standards: 'Were vital signs measured and recorded in the ED (Emergency Department) notes at any time?'. Following this audit the department put in an action plan in place, this included the audit of sepsis notes, introduction of a sepsis trolley and the recompletion of the audit as a whole.
- We reviewed eight patient's clinical records that had a diagnosis of sepsis. We found that none of these contained the 'Sepsis Six' sticker. This sticker provides a checklist of necessary treatments for those with sepsis, requiring each treatment to have a time achieved allocated. This sticker should be placed on notes once a patient had been identified as having potential sepsis from their NEWS during triage.
- The ED had a fractured neck of femur checklist, which required staff to record assessment and treatment actions such as pain scores, whether they had been x-rayed and any co-morbidities. We saw this form was used as intended on necessary patients. An audit was carried out on these forms once completed. Fascia Iliaca blocks (a simple **block** for post-operative pain relief for procedures and injuries involving the hip, anterior thigh, and knee) had recently been introduced in the department in line with RCEM guidance; training for this was delivered by the anaesthetic department. This procedure was also audited within the department; we did not see the results of this audit.
- Up to date guidance from the Resuscitation Council was displayed in each cubicle within the resuscitation area. This meant during an emergency situation staff could visualise the necessary processes and treatments. We were advised that new information was displayed following each Resuscitation Council update to ensure it was in line with the most recent evidence based guidance.
- A local audit plan was in place, which contained the current status of each audit and the clinical lead

responsible. These audits included vital signs in children, head and neck injuries and the management of encephalitis. All of the audits documented had either been completed or were in progress.

Pain relief

- All the patients we spoke with had been asked about their level of pain and offered pain relief if they required it. We observed nurse practitioners asking patients about their pain and offering pain relief during the streaming process.
- The ED had a scoring tool to record patients' pain levels. Pain was scored from 0 to10 with 0 being 'not in pain' and 10 being the worse pain the patient had ever had. Adult patients were asked (where possible) what their pain rating was. The 35 records we examined showed that pain scoring was undertaken.
- Paediatric patients were asked to score their pain using a similar numbered score, with pictures available to aid children in their decision making. We saw that this was well documented and acted on accordingly.
- The trust performed 'about the same' as other trusts in the two questions from the 2014 CQC accident and emergency (A&E) Survey relating to pain relief.

Nutrition and hydration

- All of the patients we spoke with in the majors' area of the department said they had been offered food and drink.
- Vending machines were available within the main waiting area for patients and relatives.
- We saw that staff supported patients who required assistance with eating and drinking.
- Records about each patient that we reviewed showed that staff had documented food and fluid intake effectively.
- Out of hours staff told us they could access cold foods for patients where necessary and hot and cold drinks available also.

Patient outcomes

- Information was collected and monitored about patient outcomes. The trust participated in RCEM audits so it could benchmark its practice and performance against best practice and other EDs.
- The department's scores from the Asthma in Children Clinical Audit 2013/14 were mostly in the middle 50% of all trusts. The trust's performance against two (12%) standards was in the top 25% of all trusts, with performance against the remaining three (18%) in the bottom 25%. The trust met three standards relating to the recording of initial observations. The documentation of 'systolic blood pressure' and 'peak flow' was found to be poor. Following this audit there had been the introduction of paediatric nurses into the department for the management of unwell children.
- The department did not meet any of the five standards in the Paracetamol Overdose Clinical Audit 2013/14, although performance almost reached standard in three instances, and performance was in the top 25% of trusts in England in two instances. Performance was very poor against the remaining two standards. An action plan was not in place in relation to this audit.
- In the Initial Management of the Fitting Child 2014/15 audit, the department was not measured against the one fundamental standard (no provider should provide any service that does not comply with fundamental standards). The trust met two developmental standards and performed in the top 25% of all trusts in England for the further developmental standard it did not meet (developmental standards are requirements over and above the fundamental standards).
- The department was measured against one fundamental standard and seven developmental standards in the Mental Health in the Emergency Department 2014/15 audit. The trust's score of 95% almost met the fundamental standard required score of 100% for the standard 'Risk assessment taken and recorded in the patient's clinical record'. The trust score was in the top 25% of all trusts. The department did not meet any of the developmental standards, and scored in the bottom 25% of all trusts in England for three of seven (43%) of those. An action plan had been put in place following this audit, which included improving communication with psychiatric teams to attempt to improve assessment times. It is also noted that there is a need for a dedicated mental health room to improve care for those with mental health needs, which would be put in place if a new department was built.
- In the Assessing for Cognitive Impairment in Older People 2014/15 audit, the department scored 99% against the target of 100% for the one fundamental standard 'early warning score documented'. The trust met one of the two developmental standards, and scored in the top 25% of trusts in England for the standard it did not meet. However, scores relating to

communication of findings with the GP and carer were very poor. The trust met one aspirational standard (standards used for setting long term goals) showing good communication with the admitting service. Performance against the remaining two aspirational standards, relating to communication of findings with GPs and with carers, was very poor. Following this audit the department noted the need for improved communications with GPs, and therefore letter quality was improved to ensure any identified concerns relating to cognitive impairment were clearly communicated.

- Emergency department re-attendance rates was 6.7% within seven days 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.
- All patients with non-traumatic chest pain, unplanned readmissions within 72 hours and febrile children under 12 months were reviewed by a senior clinician in line with national guidance.

Competent staff

- The way nurses revalidate their registration will change in 2016 and require more input from their managers compared to the current system. Senior staff told us they were aware of the changes and were beginning to plan how best to implement them. We saw evidence of this discussed in the minutes of monthly sister meetings.
- The initial streaming process was always conducted by an ENP, who had additional training to ensure competency in recognising patient who require prioritisation.
- Staff told us that they received yearly one to one meetings with their senior manager. Data provided to us by the trust showed that 80% of nursing staff and 82% of medical staff had received an appraisal within the last 12 months. This did not meet the trust target of 90%. Senior staff showed us action plans for the remaining staff and dates when their appraisal is booked for.
- Four trainee doctors worked within the department. They told us that they were given protected time to attend training and were provided with support to develop by senior doctors.

Multidisciplinary working

- Communication between staff was effective. Shift handovers involved staff providing detailed information on the risks, treatment and care for each patient, the staffing requirements and patient flow through the department.
- The department had access to two occupational therapists (OTs), one physiotherapist, two clinical navigators and one assistant navigator. These staff had a local agreement to allow them priority access to 22 rehabilitation beds and six beds within a nursing home.
- Staff felt the department had a good working relationship with the ambulance service. A hospital ambulance liaison officer (HALO) was in place within the department and they felt their role meant communication between the services was effective. The ambulance service also had an agreement with the ED to take blood samples in the pre-hospital setting and handover to the nursing staff once in the department.
- Senior managers and staff within the ED told us they felt multidisciplinary team working was excellent. Regular meetings were held with local social care services, the ambulance service and the local community trust. These helped to ensure all services had an overview of the current demand on the department and solutions could be sought if delays began appearing. Staff felt this whole system approach helped maintain good relationships with external healthcare partners.
- Staff told us relationships with the GP out of hours service was effective and we were told that having the out of hours service next to the department resulted in improved relationships with GPs.
- Adult and child mental health services were available upon referral, provided by the crisis team and child and adolescent mental health service (CAMHS). Staff told us that although there was sometimes a delay in their attendance they generally had good working relationships. We did not see any incident reports relating to a delay in response from the CAMHS team and evidence was not collated by the department to reflect any delays.
- There was no alcohol or substance misuse team available within the department. Staff told us that if a patient required these services then they would refer to a team externally.

Seven-day services

Urgent and emergency services

- The department had set up a referral pathway for an out of hours GP service that was based in the hospital. This meant that those requiring access to a GP outside of the operating hours of their surgery were able to do so through the department.
- The department had access to x-ray and CT services at all hours of the day and night. This meant there was no delay for patients who required imaging.
- Physiotherapy and OT services were available seven days a week within the department.

Access to information

- Staff, including agency staff, could access further clinical guidelines and pathways on the trust intranet.
- A letter was sent to patients' GP's following their attendance in the department, both if they were discharged or admitted.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We witnessed several examples of staff asking patients for permission before undertaking clinical interventions such as inserting a cannula or taking blood samples. Every patient that we spoke with said that staff had asked their permission prior to undertaking treatment.
- All nursing and medical staff we spoke with demonstrated a good knowledge of the key elements of the Mental Capacity Act 2005 or Deprivation of Liberties Safeguards and understood how it related to their care. Staff told us these topics were covered within safeguarding training.
- We spoke with three nursing staff regarding consent in children. They were able to describe the key elements of Gillick and Fraser competencies and gave recent examples within their clinical practice. A capacity policy was in place and staff we spoke with knew how to access this as required.

Are urgent and emergency services caring?

Good

We rated care within the ED as good.

Patients and those close to them gave positive feedback regarding their experiences and felt that staff went above and beyond, even during busy periods.

All staff consistently displayed caring attitudes during interactions with patients, relatives and visitors.

Patients felt involved in their treatment and well supported to made decisions.

Privacy and confidentiality was not always maintained during the streaming process due to layout of the department.

Compassionate care

- Reception staff were very respectful and polite to patients, offering them assistance with any enquiries they had. We observed examples of reception staff showing sympathy and consideration for patients when they were booking into the department.
- We spoke with 25 patients who were very happy with the care that they had received within the ED. Patients told us the department was "fantastic, they look after me really well" and that staff went "above and beyond." Some patients felt that the department was very busy but that this did not affect the care staff showed them during their treatment.
- The Friends and Family Test (FFT) is a method used to assess patients' perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. The FFT between July 2014 and August 2015 showed the percentage of patients recommending the department was worse than the England average, with results ranging from 74% in July 2014 to 86% in February 2015. However, the trust's response rate was low, typically around 20%. The trust planned to expand the use of patient experience videos to target training to specific problem areas, such as ED to improve responses.
- In relation to the 2014 CQC A&E survey, the trust performed 'about the same' as other trusts for all 24 questions relating to compassionate care. The trust scored well on questions about explanations of treatments, but less well explaining matters related to ongoing self-care.

Urgent and emergency services

- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, staff offered patients with reduced mobility assistance to move from reception to the waiting area.
- We observed caring interactions at all times during our inspection and often heard staff asking if they could make patients more comfortable and getting extra blankets and pillows for patients.
- Privacy was not always maintained during streaming when patients arrived in the department due to the size of the waiting area. Because streaming was undertaken within the main waiting area, conversations patients had with the nurse about confidential medical concerns could be overheard by other staff and patients. Patients we spoke with told us they did not feel it was private but that if they were unhappy they would request to go somewhere more private. This was supported by the nurse practitioner within this role who explained they would find a more quiet area if the patient informed them their presenting condition was sensitive in nature. This was no present within the trusts risk register, which we were told was due to the new system only being in place for days prior to our inspection.
- Curtains were drawn and doors closed when patients were assessed or treated.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and had been fully informed of their treatment and potential diagnosis throughout their visit.
- Family members 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 private room was available for those close to someone who was critically unwell. We saw this room used and that staff regularly checked on families to ensure they felt supported.
- A chaplaincy service was available for all religions were required.
- Nursing staff we spoke with explained the support they would offer to bereaved relatives and showed us the information they had available to provide them with in relation to further support and helplines.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsiveness within the ED as good.

The Department of Health target for EDs is to admit, transfer or discharge 95% of patients within four hours of arrival at ED had been met by the department since January 2015.

Any delays or problems relating to patients flow were escalated at the earliest opportunity. The escalation policy was followed to good effect within the ED.

Staff showed a good awareness and knowledge of equality and diversity and how they may need to alter their care to ensure patient's beliefs were respected.

Work was being conducted in conjunction with GPs to reduce unnecessary attendances to the department by frequent attenders.

Staff had limited knowledge of caring for patients living with dementia and tools available were not utilised within the department.

The total time patients were in ED had been longer than the England average since April 2014.

Service planning and delivery to meet the needs of local people

- The ED was open 24 hours a day, seven days a week. There were separate areas for majors, minors and the waiting area.
- Signage outside the department was not sufficient to direct people appropriately. Patients told us that the amount of signs was sometimes confusing and they often had to ask staff how to get into and also exit the department.
- Seating within the waiting area was sufficient for the amount of patients in the department at all times during our inspection. However space within the remainder of the department was limited.

Meeting people's individual needs

- Within the ED and Folwell observation unit there was a nutritional book that contained information specifically relating to religion. Each religion was listed along with the meals available, with a cross or tick to suggest whether it was suitable under their religion. This meant patients individual needs were met in accordance with their religious beliefs.
- 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.
- A translation telephone service could be accessed for patients who were unable to communicate in English. Staff told us there was a private room for this to be carried out if the patient was well enough to maintain confidentiality.
- Within the ED, we saw a range of leaflets relating to illness and injury advice; however these were only available in English. Staff told us they were not available in any other languages.
- We saw minimal information or guidance on caring for patients living with dementia. The trust used the butterfly scheme to help staff deliver the appropriate care for patients living with dementia. Whilst we saw a folder within the ED containing this information the vast majority of staff we spoke with were unaware of it.
- Staff had a good understanding of caring for patients with learning disabilities and knew how to access the lead members of staff in the hospital who specialised in learning disabilities.
- There was a private bereavement room near the majors area. We were told that the anteroom to the department's isolation room was used for viewing patients who had died.
- An audit was being conducted in relation to frequent attenders within the ED. Staffed planned to discuss the top 10 most frequent attenders with the patients GP to establish the most appropriate treatment pathways for the patient to attempt to reduce unnecessary ED attendances.

Access and flow

- ED crowding was present on the departmental risk register and appeared to be well managed. Crowding is when ambulances cannot handover their patients, there are long delays for unwell patients to see a doctor, patients on trolleys in the ED exceed cubicle spaces and patients are waiting for more than two hours for an inpatient bed after a decision to admit them. Actions had been put in place to help minimise any delays in the department, this included early escalation, effective use of the observation unit and regular reviews of peaks in demand.
- Numbers of attendances to the ED had increased from 63,724 in 2013-2014, to 67,139 in 2014-2015. However this was less than attendances in 2012-2013 which were 67,814.
- The Department of Health target for EDs is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. The department had met the 95% standard since January 2015. The department had performed better than the England average since October 2014. The performance standard was not met by the ED for four weeks during December 2014 and January 2015, but performance was similar to or better than the England average during these weeks. The performance standard was met overall in January 2015, with an average of 95.6%.
- During November 2015 there were 284 four hour breaches within the ED (4.9% of attendances). The department had no 12 hour breaches during this period.
- 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.
- Within the reception area there was a sign to inform patients how long the wait to see a doctor was, this was updated regularly throughout our inspection and was accurate.
- An escalation plan was in place to enable staff to raise acuity and capacity issues with senior hospital staff. The escalation level of the ED was discussed during the hospital's operations meetings which occurred three times daily. All senior nursing staff and the matron had a good knowledge of the escalation procedure. A log book was maintained within the department to evidence escalation levels and actions taken.
- Senior nursing staff attended bed meetings within the hospital each day. This allowed them the opportunity to advise managers and other wards on the escalation status of the department and also any factors that were reducing flow.
- Waiting time co-ordinators were in place within the ED, staffed by two full time staff and two part time staff. This

role consisted of escalating any patients who had been in the department two hours without a decision about their care being made, monitoring breaches, liaising with doctors and nurses regarding patients who may breach the four hour targets and ensuring plans were in place ready for patient discharges. Staff we spoke with felt this role was very beneficial as it allowed a focus on flow throughout the department and ensured patients delays were regularly assessed and challenged.

- During an evening inspection visit we saw managerial staff present within the ED to assist with flow, keeping staff informed of which escalation areas were open and any other actions taken to improve flow within the department.
- Folwell observation unit allowed patients requiring minimal observation and who were ambulatory to remain in this area until admission or discharge, therefore creating space within the ED for those requiring assessment or treatment. We saw this area utilised well and consistently.
- Intoxicated patients who required a prolonged period of observation were admitted to a medical assessment ward but remain under the care of ED physicians. During the morning ward round ED physicians would visit the patient on the assessment ward and discharge or admit further as necessary. Patients who were still under the care of ED but on the medical assessment ward would be documented in a red ED admissions book to ensure all staff knew whose care the patient remained under.
- Between April 2014 and July 2015, the percentage of patients leaving before being seen fluctuated around the England average. The department performed worse than England between May and August 2014. The largest percentage of patients leaving without being seen was 3.8% in May 2014, compared with the England average of 2.7%. The percentage had been better than, or equal to, the England average since September 2014. Inthe period July 2014 to June 2015,2.4% of individuals who attended ED left without being seen.
- The total time patients were in the ED had been longer than the England average since April 2014. The longest median time at the trust was 170 minutes in December 2014, compared to 145 minutes for England overall. The figures for June 2015 showed the trust improving: the median time had reduced to 147 minutes, compared to 136 minutes for England overall.
- The percentage of patients waiting four to 12 hours from the decision to admit had been better than the England average between October 2014 and the latest time point available, September 2015. A very small percentage (0.63%) of patients have waited four to 12 hours since February 2015. The percentage of patients waiting four to 12 hours was similar to the England average April to October 2014.

Learning from complaints and concerns

- The ED had received 30 complaints since January 2015, eight related to missed fractures, five related to delays in the department, five related to poor staff attitude and five related to poor communication, the remaining complaints had no theme. We did not see an action plan relating to any themes in complaints.
- Medical staff we spoke with were aware of missed fractures having occurred and if an incident was reported or a complaint received these were openly discussed to enable shared learning and to establish where mistakes were made.
- Complaints were discussed individually within the monthly sisters meetings, along with any required actions including learning points to be shared with staff.
- Within the monthly Acute Medicine Quality Group Meeting, time was allocated to discuss any learning from complaints and also any ongoing complaints. During July, August and September 2015 we saw that no complaints were discussed during these meetings.

Are urgent and emergency services well-led?

Good

We rated the ED as good for being well-led.

Working partnerships with internal and external providers were good, allowing holistic patient care.

Staff were passionate about their roles and the part they played in ensuring patients received high quality care. Staff felt valued and encouraged to develop themselves.

All staff levels demonstrated an understanding of the trusts values and vision. However, some staff felt that the forward strategy was unclear due to the uncertainty of the future of the department.

Urgent and emergency services

Leaders showed an understanding of local and corporate risk registers, quality measures and factors required to meet national targets. However, not all risks within the department had been identified on the departmental risk register.

Vision and strategy for this service

- Trust visions and values were displayed throughout the ED and staff knew about them.
- An acute medicine business plan for 2015-2017 was in place. This plan contained the service vision for the future 'To create a seamless pathway of timely quality care for acute and emergency patients which includes earliest review by a senior clinician, managing admissions and directing to the most appropriate setting for treatments.'
- The department was going through an external review of services and the future of the ED was unclear. This meant a full strategy could not be followed or acted upon until decisions had been made regarding a new ED being built. However the department had a clinical strategy in place and plans for developing a new ED department should a decision be made to construct a new building.
- Staff were unclear of the department's strategy due to the uncertainty of its future and felt that things were going to remain as they were until a decision had been reached.

Governance, risk management and quality measurement

- There was a local risk register for the ED and this was updated and maintained. Senior staff were aware of the top three risks; links between the ED and psychiatric teams not being effective, crowding within the ED and non-compliance of training and appraisals all staff in ED. However concerns raised during our inspection, including lack of risk assessment for use of the relatives' room to care for patients with mental health needs and highlighted risks relating to security and separation of the paediatric area had not been identified by senior staff.
- Not all risks within the risk register had an associated date to show when they were placed onto the risk register. This meant we could not establish if actions or improvements were put in place in a timely way.
- Most leaders demonstrated an understanding of the main risks within the corporate risk register, including failure to meet financial targets, recruitment challenges and non-compliance with training and appraisal targets.
- Weekly clinical and operational leadership meetings were established and we were told their purpose was to monitor clinical and operational workforce governance. Within meeting minutes we saw that SIs, staffing vacancies, performance and incidents were discussed within each meeting. Attendance at these meetings varied, with a low rate of nurse team managers attending, which we were told usually related to demand within the ED.
- Monthly Acute Medicine Quality Group Meetings in which quality compliance, complaints oversight, performances in relation to the four hour target and any escalation concerns throughout the acute medicine wards were discussed, were not always attended consistency by the required ED staff.
- Clinical leaders had a good knowledge of local and national audits the ED participated in and how the results of these could be used to measure quality and improve care and services.
- Within interviews with the ED leadership team we discussed what factors were helping them meet national targets and all staff showed a strong understanding of the underpinning elements that drove their good performance. Leaders explained that the ED four hour target was not just the EDs responsibility but the whole hospital had a role to play in ensuring patients had high quality and timely care within the department. They felt that this helped them continue to meet their targets.
- Division leaders had good relationships with internal and external partners which ensured a holistic approach to delivering quality within the service.

Leadership of service

- The leadership team had varying experience and length of time in the trust. One member of the leadership team had only been in post three weeks but understood the challenges the department faced and provided examples of how they felt these could be overcome. Action plans had been put in place by this newest member of the leadership team in relation to training, appraisals and other aspects of the department that had not been maintained to trusts standards previously.

- The majority of the leadership team demonstrated a good understanding of areas which required improving and how the department needed to change to provide quality care. However one senior leader did not show the necessary level of knowledge required for their role which meant some indicators to improving the service had been overlooked for a period of time.
- During interviews with the leadership team of the ED all individuals demonstrated a passion for improving the ED and maintaining its high quality care and performance.
- Staff told us that departmental leaders and senior trust leaders were visible within the department and were very approachable.
- Senior leaders told us they felt it was important to encourage staff to develop within their roles and this was supported by staff who gave us examples of training courses and development opportunities provided to them.
- Leaders explained that they felt teamwork was one of the strongest assets the department had and that it was important to continue to promote this amongst all staff groups.
- Senior leaders felt that the service could improve greatly if they had the space required within the department, and that the current layout was holding them back from implementing new ideas and changes.

Culture within the service

- We were told by nursing and medical staff that the ED was a: 'great place to work' and that: 'the atmosphere was great'. Staff told us they felt morale in the department was good and that they all staff supported each other and worked as a team.
- Staff were passionate about the roles they were in and told us the entire department placed a strong emphasis on patient care and experience. Nursing, medical and managerial staff all felt the department had a lot to be proud of and this could be further improved with a decision made about how the department was going to go forward.
- We spoke with two student nurses who told us they enjoyed their time within the ED and that it had a 'family' environment where all staff were treated as equal and worked together as a team.

Public engagement

- Patients were given the opportunity to provide feedback regarding the ED through the Friends and Family Test.
- Social media was utilised to provide the public with information relating to the ED. For example during times of high demand, to advise the public to use appropriate alternatives where available to avoid delays in care.

Staff engagement

- Medical and nursing staff we spoke with felt their opinions mattered and that any issues raised would be addressed and rectified where possible.
- Staff told us if they had ideas to improve the department they were encouraged to progress with them were suitable.

Innovation, improvement and sustainability

- Staff felt they were encouraged to look for ways to improve care and workings within the ED but that it was difficult due to the ongoing reviews and uncertain future of the department.

Medical care (including older people's care)

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

Information about the service

Bedford Hospital NHS Trust provides inpatient medical services. The trust had 15,900 medical inpatient periods between July 2014 and June 2015. Emergency spells accounted for 40% of inpatient periods, 57% were day case spells, and the remaining 3% were elective. A total of 45% of spells were reported as gastroenterology and 30% were general medicine.

The medical services are led by the integrated medicine division which also manages urgent and emergency services.

There are 12 medical wards, plus an acute assessment unit (AAU), a discharge lounge and endoscopy suite. The trust has 212 inpatient medical beds. We visited the following areas:

- Acute assessment unit (AAU)
- Arnold Whitchurch ward - frail elderly
- Cardiac catheter lab
- Carers lounge
- Coronary care unit
- Discharge lounge
- Elizabeth ward - dementia care and complex needs
- Endoscopy suite
- Godber ward - endocrinology, cardiology and respiratory medicine
- Harpur ward - dementia care and complex needs
- Howard stroke unit
- Pilgrim acute medicine ward - endocrinology, cardiology and respiratory medicine
- Primrose unit - oncology unit
- Reginald Hart ward - orthopaedic ward
- Russell ward - geriatric medicine
- Whitbread ward - gastroenterology
- Victoria day unit

We spoke with 109 members of staff including nurses, doctors, pharmacists, therapists, administrators and housekeepers. We spoke with 20 patients. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

Medical care (including older people's care)

Summary of findings

Overall, we rated the service as good for being safe, effective, caring, responsiveness and well led because:

There were excellent facilities to provide appropriate care for patients living with dementia. The trust had implemented processes to meet patient needs. However, patient information leaflets were limited to English only, and staff reported using family members for assistance with translation, which was poor practice

Medical patients in outlying wards were effectively managed and a policy was in place. Bed management meetings were held three times a day to discuss and prioritise bed capacity and patient flow issues. Discharge coordinators and the complex discharge team helped to facilitate appropriated patient discharge.

Wards were generally clean and had effective systems in place to minimise the risk of infections.

Referral to treatment performance was in line with national targets.

Incidents were reported and staff were generally aware of what preventative actions could reduce the risk of avoidable harm to patients.

Although there was a high level of nursing staffing vacancies within some teams and reliance on agency staff, staffing levels did generally meet patient needs at the time of our inspection. Medical staffing was in line was national guidance.

There was some evidence of progress to providing seven day a week services.

Mortality ratios were similar to those of similar trusts and the service had systems in place to review mortality rates. Care was provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Multidisciplinary team working was generally effective. Pain relief, was assessed appropriately and patients said that they received pain relief medication when they required it.

The medical care service was generally well-led at a ward level, with evidence of effective communication within ward staff teams. The leadership and culture promoted the delivery of high quality person-centred care as governance and risk management systems were in place in the service. The visibility and relationship with the middle and senior management team was generally clear for junior staff. All staff were committed to delivering good, safe and compassionate care.

Generally, patients received compassionate care and their privacy and dignity were maintained.

We saw staff interactions with patients were generally person-centred and unhurried. Patients told us the staff were caring, kind and respected their wishes. Most patients felt involved in planning their care, making choices and made informed decisions about their care and treatment.

However, we found that:

Not all essential equipment had been checked as required by trust procedures. Some wards were cluttered with insufficient storage for equipment. Appropriate systems were in not always in place for the prescription, storage, administration and recording of medicines.

Mandatory training compliance for staff did not meet trust targets. Not all medical staff had the required level of children's safeguarding training.

Patients did not always have good outcomes as they did not always receive effective care and treatment that met their needs. Performance and outcomes did not meet trust targets in some areas.

Most staff said they were supported effectively, but there were no regular formal supervisions with managers. Appraisal rates did not meet trust target.

Medical care (including older people's care)

Are medical care services safe?

Good

Overall, we rated the service as good for safety because:

Incidents were reported and staff were generally aware of what preventative actions could reduce the risk of avoidable harm to patients.

Although there was a high level of nursing staffing vacancies within some teams and reliance on agency staff, staffing levels did generally meet patient needs at the time of our inspection. Medical staffing was in line was national guidance.

Wards were generally clean and had effective systems in place to minimise the risk of infections.

All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, and to drive improvement in performance.

However, we found that:

Not all essential equipment had been checked as required by trust procedures. Some wards were cluttered with insufficient storage for equipment

Appropriate systems were in not always followed for the prescription, storage, administration and recording of medicines.

Mandatory training compliance for staff did not meet trust targets. Only 54% of medical staff were compliant with adult safeguarding level 2 training, against the trust target of 90%.

There was limited understanding of the major incident plan and actions that should be taken

Incidents

- There were no 'Never Events' reported in medical services between August 2014 and December 2015. Never events are defined as "wholly preventable incidents, where 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".
- The trust reported 33 serious incidents (SIs) within the medical services that required investigation between August 2014 and July 2015. The majority of SIs were due to pressure ulcers (14) and slips, trips or falls resulting in harm (13). Pressure ulcer affect an area of skin and underlying tissue and are categorised according to severity. Category one being discolouration of skin and category four being full thickness skin loss with underlying damage to muscle, bone or tendons. Category three denotes damage to full thickness of skin, but not through to underlying tissue. All SI pressure ulcers reported were category three. The trust had reported two facial category three pressure ulcers, one on Pilgrim ward and one on Elizabeth ward.
- We saw that the trust had investigated these two incidents in a timely manner and found that the injuries were caused by the oxygen mask elastic rubbing the skin on the top of the patient's ears. To mitigate against further risk and harm the trust reviewed the equipment used and sourced a less rigid alternative with the aim to reduce harm. There had been no further facial wounds reported.
- Staff told us they were aware of the electronic incident reporting system used by the trust. There was evidence to show staff were generally reporting incidents. There was evidence that incidents and their learning were regularly discussed across the medicine division at matron and team meetings. Patient safety and quality issues were also discussed. Minutes and newsletters supported this.
- 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.
- Staff were aware of the duty of candour regulation and able to describe their responsibilities. The complex discharge team had an in depth understanding of duty of candour and were able to explain the processes used by the trust in event of an incident.

Safety thermometer

- Each ward used the NHS Safety Thermometer (a national improvement tool for measuring, monitoring and analysing harm to patients and 'harm-free' care). Data was displayed for the current month, specific to

pressure ulcers, falls, catheter associated urinary tract infections, and blood clots (venous thromboembolism, VTE). Staff we spoke with were aware of the audit process and the outcomes and wards had implemented changes to reduce harms. This was particularly evident in the care of the elderly wards where red socks (socks with a gripped sole) had been implemented to reduce the risks of slips, trips and falls.

- NHS Safety Thermometer data showed medicine reported a total of 16 pressure ulcers, 23 falls with harm and 16 catheter associated urinary tract infections between July 2014 and July 2015. These were relatively small figures that could not be prevalence benchmarked against data from other organisations. The service monitored these incidents and had implemented a series of action to address the risks, For example, the trust used the SSKIN care bundle (a nationally recognised tool standing for Surface, Skin inspection, Keep moving, Incontinence and Nutrition).
- Validated safety thermometer data showed the trust had a harm free rating of 96% in December 2015.
- In addition to the NHS Safety Thermometer data, Elizabeth, Harpur, and Arnold Whitchurch wards all displayed safety crosses. This was a visible method that symbolised whether harm had occurred on that day. A red cross indicated harm and a green cross indicated no harm. On inspection, the crosses were found to be completed and indicated no harms for the previous week in all wards visited.
- All wards displayed safety information specific to the clinical area. This included the number of days since last fall with harm, pressure tissue damage and medication errors. Arnold Whitchurch's board was not updated on the day of inspection. We raised this with staff and the board was updated.

Cleanliness, infection control and hygiene

- All areas visited were visibly clean and ward cleaning schedules were in place and up to date.
- All equipment in use appeared clean. However, there was no evidence of when items were last cleaned. Staff told us that the domestic team were responsible for cleaning equipment. Cleaning schedules were in place. However, we did not see any signatory sheet in place to denote cleaning had been completed. We requested a copy of the policy for clarification on correct procedure but this was not made available to us.
- Staff had access to personal protective equipment (PPE), such as gloves and aprons. We observed this was appropriately used in most areas. However, we observed there was an incident when a nurse was observed opening patient curtains with gloved hands following personal care of the patient. Another instance was observed where nurse responded to a spillage by a patient bed, however did not wear any PPE.
- Staff were 'bare below the elbow', and washed their hands or used sanitising hand gel between patients. The trust monitored hand hygiene through monthly audits and promoted the "5 moments of hand hygiene". For August 2015, all medicine wards scored 100% for hand hygiene, except for AAU which scored 67% for nurses and 50% for doctors.
- The trust reported one case of MRSA (Methicillin-resistant Staphylococcus aureus) in the 13 months June 2014 to 2015. This was in May 15.
- The number of monthly C. difficile (Clostridium difficile) cases reached a maximum of three, with 13 reported in total during the time period. Incidence was in line with the England average until September 2015, when there was an increased incidence of C. difficile with eight cases (seven of which were in medical care wards) increasing the total yearly to nine. The service investigated these incidents and took a series of actions to minimise the risk of reoccurrence.
- A total of four MSSA (Methicillin-susceptible Staphylococcus aureus) infections were reported in the 13 months June 2014 to 2015, which occurred in three different months. Incidence was similar to the England average.
- We found that there were sharps disposal bins located, as appropriate to ensure the safe disposal of sharps, for example needles. Labels were completed to inform staff when the sharps disposal bin had been opened.
- Monthly water sampling was conducted within the endoscopy unit to ensure the water supply was not contaminated. Further, regular protein quality checks and random checks of endoscopes were carried out to ensure they were effectively decontaminated.
- There were processes and procedures in place for tracking each endoscope used. Decontamination records were filed in the relevant patient notes to ensure that equipment could be traced, including details of the staff members responsible for operating and decontaminating them.

Medical care (including older people's care)

Environment and equipment

- We inspected the resuscitation trolleys on all wards and found that daily and weekly checks demonstrated the equipment was safe and fit for use. However, daily checks were not consistently recorded on Howard stroke unit; for example, there was five days in September 2015, one day in October 2015, nine days in November 2015 where daily checks had not been recorded. We also noted that the column to record the entire contents were checked on a weekly basis had not been completed as detailed in the trust equipment check booklet. The ward manager told us that the trolley had a sealed tag in place which meant the trolley had not been opened since the last complete check. On review of the record it was apparent that checks had not been completed and recorded in line with trust policy.
- Portable equipment we checked had been serviced, maintained and tested (portable appliance testing, PAT) as appropriate, to ensure it was safe and fit for use.
- Equipment was stored in ward areas, including corridors, because there were inappropriate storage facilities.
- Dirty utility rooms (or sluice rooms) were found to be clean and tidy on inspection.

Medicines

- Medications were administered using an electronic prescribing and medicines administration (ePMA) system. The system was designed to promote safer prescribing and administration as it alerted prescribers to contraindications and risks. The system worked via Wi-Fi and during inspection it was noted that there was no guaranteed connection across all wards. This meant medication could potentially be administered and not recorded; as if a signal was not present the data entry was not captured. In addition, the system did not allow for prescriptions to be changed with stop and start dates. This was particularly relevant to antibiotic administration when the duration of treatment may be changed but the e-prescribing system did not allow for amendments to be made retrospectively. This was not recorded on the trust or pharmacy risk register.
- Paper prescriptions were used for chemotherapy medication in the Primrose unit. The plan was to move to e-prescribing. However, the timescale had not been confirmed.
- We reviewed 32 medication prescriptions. These records were clear and patient allergies to any medicines were documented.
- However, patients did not always have access to medications they needed. We saw that one patient had three missed doses of antibiotics as it was not available on the ward, and another patient missed three doses of osteoporosis medication. There were also delays noted in administration of time critical Parkinson's medications. We highlighted these concerns to staff who then reported them as incidents.
- The pharmacy team monitored completion of medicine reconciliation across all wards. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up to date prescriptions are used. This includes reviewing any GP records and discharge or transfer letters. On average pharmacy reported 70% compliance with medication reconciliation within 24 hours of admission to hospital and 90% compliance within 48 hours of admission.
- Fridge temperature checks on Pilgrim ward showed significant gaps in records. Nursing staff reported a faulty fridge which had been replaced prior to inspection.
- All wards had started to check room temperatures where medicines were stored on 7 December 2015 on a daily basis.
- Each ward had a designated pharmacist who would attend the ward every weekday and offer support and advice. This pharmacist was also responsible for checking all medication lists for patients being discharged.
- Staff on Primrose unit told us that all chemotherapy medication was prescribed by the consultant only which was in line with trust policy.
- We saw controlled drugs were stored and manage appropriately although the daily stock check described in the trust's policy was not always recorded. This meant there was a risk that the identification of discrepancies could be delayed.
- We found that medicines and intravenous (IV) fluids were stored securely in locked cupboards on the wards. However, on Elizabeth ward we observed an unsecured trolley and an unlocked drawer containing heparin injections (medication to thin blood). They were not stored securely to prevent theft, damage or misuse.
- The trust antibiotic prescribing policy required antibiotic regimes to be reviewed and resigned by the

prescriber every 48 hours. We found no evidence in patient notes or on the e-prescribing system that this had been complied with. No Patient Group Directive was observed for antibiotic prescribing.

Records

- Wards did not have a consistent approach to documentation and record keeping. Wards used a variety of paperwork which recorded the same information.
- The trust had recently introduced a SAFE chart that was designed to record daily patient care, for example, patient turning regimes, hydration, nutrition and toileting. However, not all staff knew what the chart was for and which patients it should be completed for. We asked the medicine service managers to explain the chart, but they were unaware of its implementation. Doctor also had little understanding of the meaning of the charts. There was a risk that the lack of consistency across the wards could lead to the mismanagement of patients as records were either duplicated or confusing.
- A ward manager explained that part of the daily routine was to check patient records to ensure the SAFE charts had been completed. The review of the form was one component of the quality audits completed by wards.
- The wards had up to three sections of notes in use, which included the medical notes, nursing notes and folder with patient observations and care plans. This meant that notes were not contemporaneous and promoted duplication of information. There was a risk that patient treatment and care plans were unclear to follow and staff would make decisions without reviewing all patient information.
- Medical notes were stored in unlocked trolleys at the nurses' station, on each ward. This meant when the nurses' station was not manned, there was a risk that notes could be accessed by unauthorised persons.
- There was no consistency across wards as to where paper prescription charts were stored. For example, some wards filed the charts in the nursing notes and on other wards charts were loose at the bed space.
- Nursing risk assessments were generally well completed within relevant timescales of admission. For example, patients' skin integrity was assessed within six hours of admission.
- Medical notes were found to contain signatures of entries but did not always include bleep numbers or grade of staff. Similarly nursing data entries did not always include grade or a legible signature. In line with medical and nursing registration bodies all data entries should contain details of who has completed the record to enable tracing in the future.

Safeguarding

- Nursing staff told us that they were familiar with safeguarding procedures. They were able to tell us what constituted a concern, the signs of abuse and how to raise an alert. The referral process had been completed for several patients across the wards inspected and evidence of referrals and conversations held were observed during the inspection.
- Nursing records showed relevant escalation of concerns and safeguarding referrals where appropriate. Patient's records contained details of referrals and staff were observed sharing relevant information either during handover or in ward rounds.
- Nursing staff told us the trust lead for safeguarding was visible and easily accessible. Posters were observed across the wards and in public areas with contact details of the safeguarding team.
- Staff on Elizabeth and Harpur wards told us they had a good working relationship with safeguarding team at the local authority. The wards would contact the team to discuss any concerns or known cases. This was observed on Harpur ward when the nursing staff contacted the local authority one evening to discuss an inpatient. The issue was resolved and key information emailed to the nurse in charge.
- The October 2015 trust annual safeguarding level 2 report confirmed nurse training was 89% and medical training was 54% against the trust target of 90%.

Mandatory training

- All wards reported full compliance with mandatory training figures. However, the data provided by the trust demonstrated 70% compliance in mandatory training across the division against the trust's target of 90%.
- Whitbread, Elizabeth, Harpur wards and Victoria Day unit confirmed that all mandatory training was up to date with processes in place to ensure compliance. The wards used a poster system with details of last training on the board, and sent letters and email notifications to staff when training was due. Staff told us they preferred their mandatory training to be completed in one day sessions, rather than split into individual subjects over a period of time.

Medical care (including older people's care)

Assessing and responding to patient risk

- The bed management team carried out three meetings per day. These were attended by the discharge team, ward managers, nominated lead-bed manager, senior nursing team and service manager's management and social workers. The bed meeting was well structured and methodical, looking at all pending discharges and what was needed to facilitate the discharge. The meeting also identified any outliers. An outlier is a patient who is cared for on another speciality ward, for example a respiratory patient cared for on a surgical ward. We saw evidence that outliers were reviewed by the appropriate speciality team daily.
- Patients identified as able to move to another speciality ward were risk assessed to ensure that their condition allowed for them to be moved to another clinical area and that nursing staff had the appropriate skills to care for the patient. The care of the patient remained with the admitting speciality.
- Shuttleworth ward (surgical ward) had seven medical outliers during our inspection (non -surgical patients). They were identified on the patient board with a red border and staff told us that patients were reviewed regularly by the medical doctors. Nursing staff also told us that medical doctors were easily accessible and patients received appropriate treatment.
- We observed the acute assessment unit (AAU) handover, where patients were allocated to a ward. The placement of patients largely depended on the availability of beds across the trust. This meant that a patient requiring specialist care may not be admitted to the appropriate specialist ward. We found a patient admitted to Arnold Whitchurch at night, who required non-invasive positive pressure ventilation (NIPV) the following morning, a form of respiratory support provided via a face mask. Staff on Arnold Whitchurch informed us that they had no training in NIPV. Therefore, they requested assistance from a NIPV competent registered nurse from Pilgrim ward, who attended to the patient to ensure treatment was delivered safely. The patient was transferred to the respiratory ward in the afternoon.
- We found that the hospital at night service included a clinical site practitioner, a bed manager/site practitioner, registrar, specialist trainee and junior doctor. In addition, the team utilised a clinical support worker who assisted with the cannulation and venepuncture of patients. The specialist advisor completing the investigation felt that there was sufficient provision of staff to manage the hospital at night and to respond to patient needs.
- The trust used an electronic devise for alerting the medical team on duty to incidents and "jobs" such as the need to review a patient, insert cannula and obtain blood tests. The clinical site practitioner who prioritised and allocated jobs to individuals controlled this. Each member of the team could see the jobs outstanding, and enabled them to offer assistance if they were able. This system appeared to be effective and well utilised by the team.
- The trust had implemented the wanderguard system on Elizabeth and Harpur wards. Patients known to be at risk of wandering wear a wrist band which alarms on leaving the ward and provides details of location. This enables staff to be alerted to any patients living with dementia leaving the ward unattended, thereby reducing the risk of potential harm.
- Staff told us that they completed neurological observations for all patients with an unwitnessed fall to ensure that no head injury occurred. There were not unwitnessed falls during our inspection therefore; we were unable to corroborate this.
- The ward manager on Shuttleworth ward (surgical ward) told us that they completed a risk assessment of patients living with dementia referred to the ward as a medical outlier, to ensure patients would be safe on the ward. If any concerns were raised an alternative ward would be identified, for example transfer to Elizabeth or Harpur ward.
- 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.
- Staff told us that patients were assessed on admission to wards even if they had been an inpatient elsewhere in the trust. The repeating of risk assessments enabled staff to identify any changes in condition. On Arnold Whitchurch ward a category three sacral sore was identified on admission and staff completed the relevant incident reporting documentation.

- Physiotherapists assessed patients who were admitted to hospital following a fall. The assessment identified if the patient was medically fit for discharge or in need of further rehabilitation.
- In the AAU, prioritisation for medical assessments was based on senior nursing clinical assessments and the patient's NEWS. Doctors were present in the AAU day and night so patients could be referred for an urgent medical assessment when needed.
- Patient risk assessments were reviewed across medicine, a minimum of weekly or when the patients' clinical condition changed.
- Medical staff told us that an electronic handover system was used at weekends but not in the week, where they used paper handovers. The ward based electronic handover forms were designed to have data entry by one individual at any one time to prevent information being missed/ amended.
- Speech and language therapy (SLT) had indicated that a patient on Howard ward required repositioning for meals and fluids. SLT had recommended thickened fluids to assist the patient to swallow safely. On review of the notes the patient had received normal fluids for the preceding six days. This meant there was a risk that the patient would not be able to swallow fluids safely, resulting in associated conditions such as pulmonary aspiration. This was escalated to the SLT and ward staff. SLT reassessed the patient and recommend normal fluids.
- The dementia lead told us that the trust standard was for a patient memory assessment to take place within 48 hours of admission to hospital. We reviewed 41 patients' records and found that where appropriate the assessment had taken place.
- We tracked the care and treatment of a patient admitted to ED with a suspected stroke and found they had timely assessments in ED and were admitted to Howard stroke ward within 12 hours of admission to the hospital. They were seen by a stroke consultant on arrival to the ward and all diagnostic tests had been completed in a timely manner. This was in line with national standards.
- Within the endoscopy suite all rooms had warning signs in relation to radiation at the entry point.

Nursing staffing

- Skill mix was appropriate on all wards with sufficient registered and unregistered staff to maintain patient safety during our inspection. The numbers of staff on each ward varied according to the speciality and ward activity. Staffing establishments had been reviewed in line with ward bed numbers and activity. Reviews were completed bi-annually. Staff were able to demonstrate the staffing risk assessment used to request additional staff if required. The risk assessment was completed by the nurse in charge if increased activity was noted or patients required one to one supervision. The risk assessment was then reviewed by the matron and senior nursing team to identify any staff swaps across the trust, or the employment of agency/ bank staff.
- We reviewed staffing rotas for the two weeks prior to the inspection and found that all wards had sufficient registered and unregistered staff to maintain patient safety.
- However, medical wards reported 158 incidents relating to short staffing between 1 September 2014 and 31 August 2015. This included shifts when either registered or unregistered nursing numbers were less than the planned establishment. On review of the incident forms the impact recorded resulted in delays in treatment and care, for example, delays in answering call bells and delays in medication administration. In all occasions staff had escalated the shortfall to the matron or site practitioner.
- Staff in the CCU, cardiac catheter lab, Arnold Whitchurch and Russell wards told us that they were moved from one area to another depending on staffing levels and activity. This enabled safe care and treatment across all clinical areas. Staff were only moved to areas where they had the appropriate clinical skills.
- All areas reported planned and actual staffing levels using the trust's safe staffing protocols. Wards displayed the number of nurses and health care assistants on duty.
- Ward managers were supervisory to practice. However, we observed all ward managers had an active role in ward activity, either working clinically or attending meetings.
- All wards confirmed minimal nursing vacancies. The trust reported between zero and 18% vacancies across the medical wards, most groups/ clinical areas had less than 10% vacancy rates. Staff told us that they tried to cover vacant shifts with substantive staff. However this was not always possible. Staff told us bank and agency staff covered sickness and any gaps due to vacancies. Staff told us they completed an incident form when this occurred.

Medical care (including older people's care)

- The trust employed their own bank staff who were offered to fill vacant shifts across the trust. This meant that bank staff had the knowledge of the organisation and the skills to provide care required. Bank and agency staff told us that on arrival for duty they reported centrally to the site management team for allocation to a ward.
- AAU staffing had been reduced by one unregistered nurse at night due to the previous staffing analysis, but this was being reviewed again in January 2016. CCU told us they were in the process of obtaining an additional unregistered nurse for the night shift, as their current staffing levels were not sufficient to always meet the demands of the patient group. Pilgrim ward had also had an increase in establishment as a result of increased activity.
- Pilgrim ward sister told us that the ward had a high turnover of staff with 80% of senior staff leaving in a short period of time and 90% of nurses leaving in the first six months of starting. This was thought to have been in relation to the high acuity and workload. The trust had recently reviewed the staffing levels for the ward and adjusted the establishment to increase nursing numbers.
- Staffing within the endoscopy unit had recently expanded to accommodate the refurbishment of the service. To enable training to be completed the team recruited staff in phases. This ensured that new staff were supervised and supported effectively during their induction.
- The discharge lounge could support up to eight patients at any one time. It had two qualified nurses from 8am to 6pm. The lounge also had one unregistered nurse. Staff said staffing levels were appropriate but at times, one staff member could be responsible for all of the patients whilst their colleagues were on the wards. The discharge lounge staff would attend the wards on arrival to work to assist preparing patients for an early discharge.
- Ward handovers varied according to the ward and the time of day. Staff on Elizabeth, Harpur, Arnold Whitchurch and Russell wards completed bedside handovers during the morning. The evening handover was completed in the office if visitors were present. However, we observed staff discussing patients' confidential personal information in front of other patients during the morning ward round on Elizabeth ward. We raised this as a concern to the senior nurse on the ward.
- Elizabeth ward nursing handover included information regarding short staffing. The nurse detailed that they had reported an agency nurse had not arrived for duty. This had been escalated to the night practitioner, but it was unclear if the issue had been reported as an incident.
- Poor speech and language therapy (SLT) provision was highlighted in the Sentinel Stroke National Audit Programme (SSNAP) banding. SLT was provided by a service level agreement with the South Essex Partnership University NHS Foundation Trust. The stroke service had limited availability of a SLT with only a part time band 5 therapist in post. This did not follow national guidance which recommended 1 WTE SLT for 10 patient stroke beds. This was not recorded on the local or trust risk register.
- Dietetic staff told us that they were only funded to treat patients receiving artificial nutrition on the Howard stroke ward. This meant that patients with dietary modifications, such as patients only tolerating a puree diet following a stroke, did not received dietetic support to ensure their nutritional requirements were met.
- The cardiac rehabilitation service for patients recovering from a cardiac event, did not fund dietician input. This did not meet the British Association for Cardiovascular Prevention and Rehabilitation Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation 2012, that state the delivery of the core components, requires expertise from a range of different professionals, including a dietician.

Medical staffing

- Medical staffing was appropriate across most areas; with an effective out of hours and weekend medical cover provided. However, there were pockets where regular locum staff managed caseloads. Arnold Whitchurch ward had a long term locum consultant and AAU used locum medical staff to ensure adequate staffing. The trust informed us that they used the equivalent of 761 hours of locum doctors within AAU in November 2015. This was the equivalent of one doctor 24 hours per day for the month. Medical staffing within AAU was seen to be in line with the national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication "Quality Standards in the AMU" dated June 2012.
- AAU had four consultants in post with a recruitment process in place for a fifth, hence the locum support.

This level of cover enabled a seven day service to be managed with patients seen by a consultant within 24 hours of admission. The cover provided a consultant on site between 8am to 8pm, with slightly reduced service at the weekend (8am to 6pm). Medical staff within AAU told us that were well supported and had appropriate training in place to support them clinically. This included the Medical Royal Colleges Medical Training Initiative (MTI) which is a two year programme for overseas doctors to support learning specialist and individually tailored clinical development.

- The proportion of consultants (40%) was about the same as the England average (39%), and the proportion of junior doctors (22%) was higher than the England average (15%). The proportion of registrars (30%) was lower than England average (38%).
- Consultants carried out regular board rounds either daily or three times per week.
- Ward rounds were completed on named days and varied from twice weekly to three times weekly. Medical ward rounds on Elizabeth ward occurred twice weekly and thrice weekly on Pilgrim ward.
- The medical staff on Elizabeth ward told us that there was no set times for ward rounds at weekends. Consultants were onsite and saw the acutely unwell patients and new admissions only.
- We observed the clinical handover between day and night medical teams. This included the handover of the acutely unwell patients across the trust. Patients identified as being at risk were discussed to ensure oncoming staff were aware of interventions or assessments required overnight.
- The gastroenterology lead told us that they offered continued clinical development and observational sessions for their consultants, whereby peers could observe procedures and offer training and advice. This was timetabled in the work plans for the staff.
- An effective on call rota was in place to manage gastrointestinal bleeds which provided out of hours service facilities for patents requiring an urgent endoscopy.
- The cardiology team utilised one doctor to work between Milton Keynes University Hospital and Bedford Hospital in either the cardiac clinic or catheter lab. This promoted shared learning across the organisations.
- Staff on Shuttleworth ward told us that they were unable to admit patients over 60 years old as the geriatrician would not attend the ward. It was reported that on occasion when patients over 60 had been admitted to the ward the geriatrician had insisted that the patient be moved before being assessed. This situation had been escalated to the matron however the outcome was not known. Staff did not report any incidents relating to this.

Major incident awareness and training

- The bed escalation policy and major incident plan was available on the trust's intranet and were updated in 2015. Staff were aware of the policies and how to access them.
- The trust had appropriate plans in place to respond to emergencies and major incidents. However staff we spoke with had limited awareness of what actions they would take in the event of a major incident, including a fire. The exception of this was the cardiac catheter lab, where staff were able to describe actions to be taken in the event of a major incident.
- The trust had additional clinical 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 trust had an escalation plan and action cards in place for all staff.

Are medical care services effective?

Good

Overall, we rated the service as good for being effective because:

Mortality ratios were similar to those of similar trusts and the service had systems in place to review mortality rates.

Care was provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in.

Multidisciplinary team working was generally effective. There was some evidence of progress to providing seven day a week services.

Pain relief, was assessed appropriately and patients said that they received pain relief medication when they required it.

However, we found that:

There was a significant deficit in speech and language therapy services for patients who had experienced a stroke and limited provision of podiatry care for diabetic patients.

Most staff said they were supported effectively, but there were no regular formal supervisions with managers. Appraisal rates did not meet trust target.

Evidence-based care and treatment

- Assessments for patients were generally comprehensive, covering all health (clinical needs, mental health, physical health, nutrition and hydration needs) and social care needs. Patient's care and treatment was generally planned and delivered in line with evidence based guidelines. For example, the service used a care bundle based on national guidance for the management of acute kidney infections.
- The trust had a process of quality checks which were performed by ward managers at regular intervals. This included the review of documents and the completion of patient risk assessments. Senior nursing staff reported that the number of quality checks completed daily varied from a few patients to all depending on ward activity. Findings from the quality checks were shared with individuals on duty at the time and at team meetings.
- We saw that the trust used the SSKIN care bundle (a nationally recognised tool standing for Surface, Skin inspection, Keep moving, Incontinence and Nutrition) for minimising the risk of skin damage. This was effectively followed in all the care plans we looked at. Appropriate pressure relieving equipment was in place and we saw that patients had been reviewed by a tissue viability nurse (TVN) when required.
- Howard stroke ward had policies in place that followed the national institute for clinical excellence (NICE) guidance for stroke in adults. Staff showed awareness of the stroke care pathway and we saw effective treatment planning in nursing and medical records.
- We saw evidence that the ward's standardised therapy assessments tools were based on national guidance, for example use of the Montreal Cognitive Assessment (MOCA) tool and Barthel Index.
- The hospital had a policy for management of sepsis (blood infection) based on national guidance, and a sepsis bundle care pathway implemented if sepsis was suspected. Wards did not have "sepsis boxes" available but did have access to appropriate antibiotics from pharmacy. This meant there was a risk that there could be a delay in obtaining all equipment necessary to commence treatment for sepsis. We did not see anyone being actively treated for sepsis during inspection.
- We saw the trust followed the policy for administering chemotherapy, which was in line with national standards.
- Staff on Harpur and Elizabeth wards told us that they were completing quality markers for the Royal College of Psychiatry's elder-friendly hospital wards. This is a framework that identifies ward actions that reduces risk and anxieties of patients living with dementia. The team had suggested the participation in the process to ensure that they were providing the best care possible for the patients. The team had recently completed the first part of the assessment and their certificate of accomplishment displayed on the ward.
- The endoscopy department had been refurbished and opened in December 2015. The facility had clear clinical and waiting areas. Endoscopy services were Joint Advisory Group (JAG) gastrointestinal endoscopy accredited, which meant that the service met the accreditation standards framework such as policies, practices and procedures.
- The ambulatory care unit had a series of care bundles in place, based on NICE guidance for suspected and confirmed pulmonary embolism, cellulitis and deep vein thrombosis.

Pain relief

- Patients said that they received pain relief medication when they required it.
- Howard ward staff informed us that they use the Abbey pain scale for patients with known dementia who could not communicate effectively. This scale enabled nurses to identify physical signs that would suggest the patient was in pain, such as facial expressions and behavioural changes.
- We saw patients' pain was assessed and recorded on NEWS charts. Records examined showed that patient's pain relief was reviewed regularly and appropriate pain relief was generally given as prescribed when required.
- The trust's pain team were available Monday to Friday. The team consisted of nurse prescribers who assessed patients and offered advice. Referrals were made by telephone call and staff reported a quick to response by the team.

Medical care (including older people's care)

Nutrition and hydration

- We saw patients were screened for risk of malnutrition on admission to hospital using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST).
- Staff accurately recorded patient's oral diet intake on SAFE charts.
- Patient fluid intake was also recorded. However, none of the 34 nursing records reviewed stated a target fluid balance or escalation plan in the event of poor oral fluid intake. Fluid output (urine) was not recorded by volume and charts were noted as stating "out to toilet" where the volume should have been recorded. This meant that accurate fluid balances could not be established.
- Most wards had protected meal times and patients generally had a choice of meals. Appropriate finger foods were provided when required for patients living with a dementia.
- Dietetic support could be accessed by a telephone referral.
- We saw dietetic reviews documented in patients' medical notes, highlighting the implementation of nutritional supplements. Nutritional supplements included fortified soups, drinks, and yoghurts.
- We saw that wards used red trays and red jugs to indicate patients who needed assistance or who were at risk of malnutrition or dehydration. This was observed on Elizabeth ward when staff assisted patients with eating and drinking during meal times.
- The discharge lounge provided sandwiches and drinks to patients awaiting transfer but did not generally have access to hot meals.

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).
- 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 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.
- In the hospital intelligent monitoring report for May 2015, the indicator 'Composite indicator: In-hospital mortality, cardiological conditions and procedures' was rated as risk. Although it had improved since the December 2014 report where it was an elevated risk. The trust had subsequently received notice of the closure of this risk.
- The service had an annual local clinical audit plan in place, for completion of nationally recognised assessments such as the VTE and the MUST. They also took part in regional and national audit programmes including the audit of febrile neutropenia in oncology patients (CG15) and the National Chronic Obstructive Pulmonary Disease Audit.
- In the September 2015 national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) the trust was rated as band D (A being the best and E the worst). The service had an action plan to address these concerns.
- SSNAP data was collected both electronically and in paper format and entered into the database by an administrator. Allied health professionals (AHPs) within the stroke team told us the database for SSNAP could only be accessed by one person at a time. This meant that staff were often waiting to capture activity.
- The hospital performed better than the England average in the most recent published Myocardial Ischaemia National Audit Project (MINAP) audit for 2013/14. The trust did not measure thrombolytic door to needle time as patients requiring emergency treatment were transferred to the regional centre. Patients were then referred back to Bedford Hospital on discharge from the regional centre for management of ongoing treatment.
- The hospital performed similar or better than the England and Wales average in the latest published

National Heart Failure Audit (NICOR/ HQIP) for 2013/14 including input from cardiologists and specialists. The exception of this was referral to heart failure nurse specialists which was worse than the England and Wales average.

- For the most recently published National Diabetes Inpatient Audit (NaDIA) in September 2013, Bedford Hospital performed better that the national average in 12 out of the 20 audit measures and worse than median in seven. The trust scored well against medication, prescription, management and insulin errors. Diabetic foot care scored poorly and this was escalated to the trust board. The lack of sufficient podiatry services was on the local and trust risk register with plans in place to recruit to the vacancy.
- Data from the National Lung Cancer Audit 2014 found that the trust discussed a slightly lower percentage of patients at multidisciplinary team meetings than the England average (93% of trust patients compared with 96% nationally). The trust also had a lower percentage of patients receiving a computed tomography (CT) scan before bronchoscopy (82%) than the England average (91%). Trust performance did not meet the 95% standard in either case.
- The relative rates of readmission for both elective and non-elective patients were slightly better than expected. The risk of readmission for elective medical patients was 96 and for non-elective patients was 94 which were better than the England average of 100 for each category. The risk of readmission for general medicine was higher than expected at 167. Senior management confirmed that readmission rates were monitored on a daily basis and the details behind each readmission was reviewed. For instance, detail of whether the readmission related to the same or new medical condition.

Competent staff

- Generally, we found there were effective induction programmes for new permanent staff, bank and agency staff and students that were not just focused on mandatory training. Learning needs of staff were identified through a training needs analysis, and competency packages were developed. This was observed on the CCU, Elizabeth and Harpur wards where competency packs and mentors were allocated on commencement in post. We saw competencies were also available for unregistered staff and AHPs.
- Victoria day unit staff had been trained in additional clinical skills to meet patient needs. This included specialist infusions, line insertion and drains. The staff told us that they attended external training for the specialist skills required for their roles.
- Nursing staff had the opportunity to attend the University of Bedfordshire to complete specialist courses. We spoke to individuals who were attending university for courses in care of cardiology patients, the frail elderly and stroke patient modules. The courses included weekly lectures, competencies and written essays.
- Staff told us there was no formal clinical supervision provision. However, staff said informal support from their managers was effective and provided when they needed it. Senior staff said they received excellent informal support from their line managers.
- Data provided by the trust demonstrated that the appraisal rates in the medicine service were largely below the trust target of 90%. Individual ward managers confirmed compliance of appraisals between 50 to 100%.
- Medical appraisal compliance did not meet the trust target of 90%. Average compliance was 84%, within dermatology compliance was 50% and there was 100% compliance in neurology, rheumatology and diabetes.
- The gastroenterology team continued to use peer review for clinical development and roster joint lists to enable observation and training.
- Junior doctors said senior support was effective and that generally the quality of teaching was very good.
- The trust offered two levels of dementia training. Level 1 and level 3. Level 1 provided leaflet information and face to face training by the trust. This included a video presentation completed during induction for all staff. Level 3 training was mandatory for all staff on the care of the elderly wards. Additional specialist training was available at the University of Bedfordshire (dementia care module) for staff from dementia care wards.
- In terms of medical staff revalidation, 47 doctors had been assessed in 2015, with another 20 to be completed by the end of the year.

Multidisciplinary working

- A multidisciplinary team (MDT) were well attended across all wards. MDT meetings took place on a regular basis to review the progress of patients and plan a safe

discharge. The MDT on Howard and Harpur wards were observed to be systematic, with staff showing insight into individual patient needs and what was required to enable a safe discharge.
- We observed information from MDT meetings shared with the wider nursing team on Harpur ward.
- The heart failure specialist nurse told us that she attended the consultant ward rounds twice weekly. This enabled patients to be identified for the for the cardiac rehabilitation programme. This was not observed during inspection.
- Nurses said that relationships with doctors and other professionals were inclusive and positive and facilitated effective MDT working.
- Nursing staff reported a good working relationship with community services.

Seven-day services

- There was some evidence of progress to providing seven day a week services.
- Newly admitted patients were seen by the on call consultant at weekends.
- The AAU consultants provided seven day cover. All patients were seen within 24 hours of admission by the consultant.
- The out of hour's medical team consisted of a registrar, specialist trainee and junior doctors plus an on call consultant. The trust has a clear escalation procedures. All wards reported that at weekends, the consultant reviewed acutely unwell patients and new admissions only.
- The cardiology team provided an outreach service to assist with the identification and treatment of suspected myocardial infarction. The team worked between 9am and 5pm Monday to Friday. Out of hours the service was managed by the staff on CCU. Emergency cardiology patients were transferred to alternative trusts 24 hours per day.
- The stroke service offered emergency treatment for patients between 9am and 5pm Monday to Friday. Outside these hours patients were transferred to Luton and Dunstable University Hospital.
- Cardiac catheter lab operated a Monday to Friday service with primary cardiac patients transferred to the regional centre. Staff told us that any inpatient requiring this service out of hours would be monitored and if necessary transferred for urgent treatment.

Access to information

- Staff used an electronic discharge checklist for each patient. In addition, staff completed telephone handovers to other hospitals and nursing homes.
- Doctors completed electronic discharge summaries to ensure appropriate information was available to healthcare professionals regarding patients' discharges.
- Generally, doctors and nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.
- Policies were available on the trust's intranet and staff were aware of how to access them.

Consent, Mental Capacity Act and 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. Most wards had trust posters on display giving information regarding mental capacity and Deprivation of Liberty Safeguards (DoLS). Nursing staff explained best interest decisions were made in conjunction with the medical staff, and if relevant a best interest external assessor would be contacted.
- The senior nurses on the dementia care wards told us that the ward sisters were responsible for completing safeguarding referrals and tracking changes or outcomes. We observed the ward sisters demonstrated an in-depth knowledge of their patients and the processes currently in place.
- Weekly tracking lists were shared with wards sisters relating to patients with either an MCA or DoLS in place. This enabled staff to plan care and track actions required to enable safe treatment and discharge.
- Therapists told us that a patient's verbal consent was always obtained before carrying out treatment plans. This was clearly recorded in patients' notes.
- The dementia lead nurse told us that 88% of all nursing staff had received MCA and DoLS training. This nearly met the trust target of 90%.

Medical care (including older people's care)

Are medical care services caring?

Good

Overall, we rated the service as good for caring because:

Generally, patients received compassionate care and their privacy and dignity were maintained

We saw staff interactions with patients were person-centred and unhurried.

Patients told us the staff were caring, kind and respected their wishes.

Most patients we spoke with were complimentary and full of praise for the staff looking after them.

The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams. Response rates were the same as the England average and recommendations rates varied from ward to ward.

Most patients felt involved in planning their care, making choices and made informed decisions about their care and treatment.

However, we found that:

Some patients were not closely involved in the multidisciplinary meetings and decision making about their plan of care and discharge.

Compassionate care

- Patients and those close to them were generally treated with respect, including when receiving personal care. Nursing staff and care support workers helped to promote privacy and dignity by using clipped posters that were attached to curtains to signify personal care was taking place. Staff were requested to knock before entering or wait until the procedure was completed.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with patients and those close to them. Staff spent time talking to patients, or those close to them. Patients generally valued their relationships with staff and experienced effective interactions with them.
- Staff generally respected patient's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- On Elizabeth ward, patients were asked how they preferred to be addressed and this was placed on a board above their bed space. The board also detailed relevant communication information, for example if they were hard of hearing or were visually impaired.
- Patients were positive about the care they received on the wards. Staff were proud of the positive feedback they received from patients.
- Confidentiality was generally respected at all times when delivering care, during staff discussions with patients and those close to them and in any written records or communication.
- Staff supporting patients by providing one to one supervision were observed to be polite and considerate to the patients' needs.
- The trust had a 33% response rate in the Friends and Family Test (FFT) for medical wards between July 2014 and June 2015. The wards had recommending scores between 67% and 100%. For example, the coronary care unit consistently scored very well, with 93 to 100% of monthly respondents recommending the unit, with a response rate of around 60%.
- The performance in the CQC Inpatient Survey, published in May 2015, was about the same as other trusts in all questions. 361 patients took part in the survey.
- The trust participated in the National Cancer Experience Survey, which was published in September 2014. Between 1 September and 30 November 2013, 229 eligible patients from the trust were sent the survey, and 143 questionnaires were returned completed. This represented a response rate of 68% once deceased patients and questionnaires returned undelivered had been accounted for. The national response rate was 64%.
- The trust scored in the top 20% nationally for 16 of the questions including being given clear information. The trust was in the middle 60% of trusts for their performance against 41 indicators. The trust scored in the lowest 20% in 13 indictors, including overall rating of care.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- Most patients felt involved in planning their care, in making choices and informed decisions about their care and treatment. However, we found that generally, patients were not closely involved in the multidisciplinary meetings and decision making about their plan of care and discharge.
- Staff communicated in a way that patients could understand and was appropriate and respectful. We observed staff involving patients and those close to them during assessments on the ward. If the patients' relative had any questions, staff were able to discuss these at the time.
- We observed therapists supporting and involving patients appropriately with their therapy assessments on the stroke ward.
- We found medical staff generally took time to explain to patients and those close to them the effects or progress of their medical condition.
- We saw some evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care.
- Wards had a named nurse system so patients and their relatives generally knew who was looking after them.

Emotional support

- Most patients we spoke with were very positive about the support they had been offered by the multidisciplinary team.
- Staff showed awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required.
- Psychologist support from the community was available when required.
- We observed staff managing a complaint in a sensitive and supportive manner.
- Staff on the Primrose unit told us they had access to the Helping Overcome Problems Effectively (HOPE) programme which identifies skills to promote support, and well-being. This was reported as contributing to the patient experience.
- The Primrose unit offered an information centre for patients and relatives which were noted as being very valuable to patients. This was a joint service provided by the trust and the local Macmillan team.

Are medical care services responsive?

Good

Overall, we rated the service as good for responsiveness because:

Referral to treatment performance was in line with national targets.

There were excellent facilities to provide appropriate care for patients living with dementia. The trust had implemented processes to meet patient needs, for example, Whitbread staff told us they provided patients discharged with snack boxes or milk and bread to support their initial period at home.

Bed management meetings were held three times a day to discuss and prioritise bed capacity and patient flow issues. Discharge coordinators and the complex discharge team helped to facilitate appropriated patient discharge. Staff told us they worked closely with community teams to promote an early discharge of patients living with dementia.

Concerns and complaints procedures were established and staff generally used the Patients Advise and Liaison Service (PALS) to manage complaints.

However, we found that:

At times there were elevated demands on medical bed availability, which resulted in a high number of outliers. Medical patients in outlying wards were effectively managed and a policy was in place.

Patient information leaflets were limited to English only, with access to translators as necessary. Staff reported using family members for assistance with translation, which was poor practice.

Service planning and delivery to meet the needs of local people

- 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.

- The trust had 16 coronary care beds and a cardiac catheter laboratory which was for diagnostic tests only. Acute cardiac interventional services were provided at Papworth Hospital. Staff told us patients remained at Papworth Hospital until they were fit for discharge. As a result of this, patients managed on CCU had changed from acutely unwell, to those requiring management of long term conditions, such as heart failure. Staff had the relevant skills and competence to meet the needs.
- Out of normal working hours the Victoria day unit was used to accommodate additional beds when capacity demands were high. Patients planned for discharged the following day were transferred to the area. The trust had an escalation standard of practice in place which outlined a checklist to ensure patients were safe and a patient suitability risk assessment was completed. Additional nursing staff managed the area. We observed that trolleys had been removed in favour of six beds but no patients were allocated to the area.
- The discharge lounge provided facilities to meet needs of up to eight seated patients awaiting transport for discharge. Bedbound patients were unable to attend the discharge lounge due to lack of facilities for transferring and space. Therefore remained on the ward until collected by transport.
- The trust had implemented a navigation team which consisted of a discharge co-ordinator, physiotherapist or occupational therapist. Referrals were made for patients expected to be medically fit within the next 72 hours. Patients were assessed and any aids for discharge requested, for instance walking frames and sticks, rails and chair raisers. The team ensured that patients knew how to and were confident in the use of the aids for discharge. This process assisted with the identification of need for additional support and consequential referrals to care or support agencies.
- 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 not observed during inspection.
- Patients requiring acute care for renal diseases were managed by the regional centre another local NHS trust and transferred back to Bedford Hospital for ongoing care.
- The Victoria day unit was open between 7.30am and 8pm and provided a service for clinical pathways such as the management of cellulitis, and deep vein thrombosis. Treatments were completed as outpatient appointments to prevent some admissions to hospital. The team had a resident doctor who managed treatments and offered clinical support to the nursing team. Referrals were taken from both GP and emergency department.
- The tissue viability nurse told us that all mattresses were being reviewed as the contract in place was due to end with planned replacement taking place early 2016.

Access and flow

- Cancer services were shared with the regional centre at a nearby NHS trust. The trust reported two week waiting times were achieved for 92% of referrals in December 2015. The 31 day target for referral to first treatment was achieved in 100% of patients in December 2015.
- In June 2015, the admitted and non-admitted operational standards were abolished. The incomplete pathway standard was the sole measure of patients' constitutional right to start treatment within 18 weeks. The trust had consistently met the historical standard for referral to treatment since at least July 2013. It had performed better than the England average since October 2013.
- Bed management meetings were held three times a day to discuss and prioritise bed capacity and patient flow issues. The service used a nationally recognised bed capacity "predictor tool" to forecast bed capacity and demand.
- The trust had a consistent number of ward moves per patient during the past two years, 48% of individuals had at least one ward move.
- In November 2015, there were 103 medical patient moves at night (after 10pm). 95 of which were from the AAU 12 hour assessment bay. Information provided by the trust did not specify if the moves were due to clinical needs or bed management issues. The trust had a draft policy in place regarding patient moves which stated patients should not be moved after 10pm unless there

was a clinical need, and those patients moved should be risk assessed for the impact of the transfer. During inspection we saw that patients had been appropriately risk assessed and transferred out of hours.

- During our inspection, there were 20 additional medical patients on surgical and gynaecology wards. Trust data confirmed that 294 medical patients had been placed on other speciality wards for a total of 1839 days in 2015/16. The trust reported no cancellation of surgical procedures as a result of medical outliers.
- Service managers and ward staff told us medical teams were assigned to each surgical ward to manage the care of medical outliers. Nursing staff told us medical teams visited medical outliers after the main ward rounds
- Discharge coordinators were allocated to watch ward and tracked progress against discharge planning. They also assisted with the completion of single assessment forms which were the referrals for additional support or care.
- Patients identified as requiring enhanced community support (approximately 20% of inpatients) were managed by the complex discharge team. The team consisted of nurses and AHPs, such as physiotherapists and occupational therapists. The team reviewed all patients who were in hospital over five days. The team identified any problems and worked with the ward to track and facilitate referrals and assessments in a timely manner. The team assisted a variety of patients' discharges including end of life care and patients who were non-weight bearing.
- The average length of stay for elective patients was three days compared to the national average of 3.8 days. Average length of stay for non-elective patients was 6.5 days in comparison to the national average of 6.8 days. The average length of stay for elective medical patients was slightly shorter than the England average. Within specialities, gastroenterology patients had a longer than average length of stay due to the inclusion of patients with alcoholic liver disease in the category. Length of stay for non-elective medical patients was similar to the England average.
- The diabetes specialist nurses' worked with the community diabetic team to provide joint appointments for patients making the transition from children's and adult services. The team were located centrally to facilitate shared learning.

Meeting people's individual needs

- The trust had 61 designated beds for people living with dementia.
- Elizabeth and Harpur wards had been designed to care for patients living with dementia. Facilities included under bed lighting, 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 assisted patients to differentiate between beds and flooring at night and wards reported a significant decrease in falls as a result. Harpur ward had 87 reported falls in 2014 compared to 69 in 2015. The estates work had been funded by the Kings Fund.
- The wards also used a "Tag" system whereby patients with confusion or at high risk of falls were grouped into one bay. A staff member would be allocated to the area at all times.
- Staff told us that low beds were available for patients at risk of falling from bed.
- Staff used a butterfly symbol to identify patients with a confirmed diagnosis of dementia, or an outlined butterfly to identify patients that may be confused. The symbol was placed on the ward board next to the patients name to help identify patients at risk. Staff told us before the butterflies were used the relatives' permission was sought to ensure that they were happy with the open display.
- Provisions of activities across the trust for patients living with dementia were found to be of a high standard Dementia boxes and activity blankets were widely available for patients living with dementia. These were boxes with memory aids and activities, which were designed to either assist patients to recall events and experiences or to provide activities to occupy the patient. 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. This helped staff to meet the specific needs of patients living with dementia.
- Patient information leaflets were available on the Howard stroke unit, including specific condition and stroke prevention information. We did not see any leaflets in non-English languages and staff confirmed these were not available. Staff had access to interpreters and knew how to access them. Staff told us that patients' family members were used to translate if

necessary, despite being poor practice. Staff also told us that in cases where family members were used to assist with translation, visiting times were extended to ensure patients could communicate with the team.
- The complex discharge team also told us they used family members or translators for discharge meetings.
- Nursing staff told us that visiting times could be flexed to allow relatives of elderly patients to maintain family contact through long admissions.
- The cardiology specialist nurses provided a cardiac rehabilitation service for patients who had been admitted to hospital with a cardiac event. Patients completed either a four week or six weeks programme according to original illness.
- Some wards had quiet areas for patients and relatives to use. Patients had access to a chapel and multi faith room on site. Wards had access to spiritual support.
- Patients were able to access the trust's carers' lounge, which offered drop in advice and assistance to relatives or carers of patients.
- Whitbread staff told us that they had implemented a hostess at weekends to support gastroenterology patients with meals following identification of need at an innovation event held by the trust. Staff told us this was working well. The review date for this was unknown.
- Whitbread staff told us they provided patients discharged with snack boxes or milk and bread to support their initial period at home. This was introduced as patients were not always able to confirm that meals / shopping was in place on the day of discharge.
- Victoria day unit staff told us they flexed their working day to meet the needs of the patients attending the department. This resulted in appointments made outside normal working hours to allow patients to have a normal home / work balance.
- There was a lead learning disability nurse who staff can contact for advice and support.

Learning from complaints and concerns

- Patients generally knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care.
- Complaints procedures and ways to give feedback were in place. Patients were supported to use the system using their preferred communication method. Patients were informed about the right to complain further and staff encouraged patients to use the Patient Advice and Liaison Service (PALS).
- There were 202 medical complaints between October 2014 and December 2015. These related to staff attitude and behaviours, poor communication and poor nutrition. AAU and Pilgrim wards had 27 and 25 complaints respectively. The trust reported 45 days as the average time taken for trust response to complaint, however data analysis showed an average of 57 days. The trust complaint's policy did not outline a response time as this was determined on receipt of the complaint and dependant on the investigation required. Plans were in place to reduce the trust response time target, to improve complainant satisfaction.
- We saw many compliment letters and thank you cards displayed in ward areas.

Are medical care services well-led?

Good

Overall, we rated the service as good for being well led because:

The medical care service was generally well-led at a ward level, with evidence of effective communication within ward staff teams.

The leadership and culture promoted the delivery of high quality person-centred care as governance and risk management systems were in place in the service.

The visibility and relationship with the middle and senior management team was generally clear for junior staff.

All staff were committed to delivering good, safe and compassionate care. Innovation was encouraged by the service.

However, we found that:

Clinical specialities demonstrated no shared medical division strategy.

Not all junior staff were fully aware of the vision and strategy of the trust.

Vision and strategy for this service

- The trust overall had a statement of vision and values, but not all staff at all levels in the medical division were fully aware of this vision. Staff who were aware told us that the vision and values had been part of their interview process.
- There was no service specific written strategy for the medical division and specialities did not appear to have a shared vision or aim.

Governance, risk management and quality measurement

- The senior management team maintained the main risks for the division. Risks identified included the lack of podiatry services for patients with diabetes, insufficient staffing on Pilgrim ward and the cardiac catheter lab being used to managed inpatients during periods of high activity. Managers reviewed risk registers regularly. These were observed during inspection.
- Ward staff told us wards maintained their own risk registers. Risks were numerically graded according to the likelihood and impact. A score of one to 25 was possible with higher numbers demonstrating higher risk. Risks 15 or above were included on the trust risk register and were escalated through regular quality and clinical risk committee meetings. Senior staff said the main risks identified for the service were regarding staffing pressures.
- Russell and Arnold Whitchurch ward managers identified the main risk as falls. The incidence of falls was monitored locally by the wards. Actions had been taken to reduce the occurrence. For example, the implementation of slipper socks, grouping of patients and the use of chair alerts.
- The medical division held two quality meetings which were separated into acute medicine and speciality medicine. The meetings were attended by the service managers, clinical leads and matrons and reported to the quality board.
- Nursing staff in the cardiac catheter lab told us they attended governance meetings quarterly. The agenda was set and covered targets, audits (both local and national), policy reviews, incidents and service improvement ideas. Minutes were taken to the trust board by the cardiology clinical director. We saw copies of the minutes during inspection.
- The cardiology team completed annual policy reviews to determine requirements for updating before their expiry. The reviews were then allocated to the most relevant person within the team.

Leadership of service

- Staff and leaders in the wards generally prioritised safe, high quality, compassionate care and promoted equality and diversity.
- The majority of staff felt respected, valued and supported. Local ward leaders communicated effectively and were visible to teams and staff.
- Endoscopy and ward nursing staff reported they generally felt supported by their line manager.
- Most staff said the chief executive and senior leaders were visible and feedback from management was improving but varied.
- Local teams generally had clearly defined tasks, membership, roles, objectives and communication processes.
- The complex discharge team told us they worked closely with the chief operating officer and found that they were able to discuss any concerns or specific patient issues relating to the flow of patients through the organisation.
- We saw ward managers told us they attended their wards earlier than necessary to ensure they saw all staff and participate in ward handover.

Culture within the service

- Across all wards staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Most staff felt listened to and involved in changes within the trust. Many staff spoke of involvement in staff meetings and received newsletters.
- Senior managers said they were well supported and there was effective communication with the executive team.
- Staff did not express concerns about bullying or harassment. Senior staff complimented the attitude and dedication of all staff in the service.
- The discharge team told us consultants understood pressures of bed management and worked to identify patients who could be discharged home with additional support.

Public engagement

- The trust and staff recognised the importance of the views of patients and the public. A standard approach was taken to seek a range of feedback with participation and involvement with both the public and staff including surveys, comment cards and questionnaires.
- Information on patient experience was reported and reviewed alongside other performance data but not all staff felt patient feedback was used to make informed decisions about the service.
- Some people who attended our listening event, where we invited the public to speak with us about Bedford Hospital, told us that they were part of trust organised patient support groups. They told us that they provided peer support for newly diagnosed patients in a condition that they were already diagnosed with, for example, cardiology and neurology conditions.

Staff engagement

- All wards reported regular team meetings and newsletters between meetings. Information was shared electronically to email accounts, in addition to paper format. When areas were jointly managed, joint team meetings were completed. For example, Arnold Whitchurch and Russell wards were managed by the same ward matron who conducted team meetings across both wards.
- Medical and nursing staff within endoscopy had been involved in the design and development of the department to ensure the service was suitable to needs of the patient and staff.
- Staff had been involved in the purchasing of equipment. This included the trialling of equipment before voting on items to be purchased.

Innovation, improvement and sustainability

- A student nurse had designed and introduced a visual aid to facilitate patient turning on Russell ward. The aid was a clock face which was placed above a bed-bound patient's bed detailing what time intervention was next due. The visual reminder was well used across the ward. However, on review of patients notes the records did not reflect the turn clocks in use.
- The respiratory specialist nurses provided an acute respiratory assessment service. This enabled patients with a history of COPD to contact the specialist team to gain support and advice. COPD patients were frequently admitted to hospital due to the complexity of the illness. The service was designed to enable patients who were struggling at home the ability to speak to the specialist nurse. The nurse would complete a telephone assessment and make a clinical decision either to see the patient at home, bring their next outpatient appointment forward, or suggest immediate treatment by accessing the emergency department. The nurse would then meet the patient in the emergency department to provide immediate treatment on arrival. The service had been working with the emergency services to provide training and offer advice to assist in preventing admissions to the hospital. The service worked 9am to 5pm Monday to Friday.
- The trust had implemented a hospital at home service which provided care for patients who were suitable to receive treatment and monitoring at home. The team worked 8am to 8pm and saw up to seven patients per day. Referrals were made by telephone. The patient received treatment at home and remained under the direction of the consultant. The service enabled patients to be discharged sooner than previously. The team were collecting data to identify productivity and informed us that since commencing the service in August 2015 they had saved 1217 inpatient days.

Surgery

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

Information about the service

Bedford Hospital NHS Trust has one main location: Bedford Hospital.

The trust provides a range of 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's main Clinical Commissioning Group (CCG) is NHS Bedfordshire CCG.

The trust provides surgical service provisions including general surgery, orthopaedics, trauma, ear, nose and throat (ENT), vascular, breast surgery, urology, plastic surgery and oral and maxillofacial surgery. There are 116 surgical beds over three wards and one surgical assessment unit, nine theatres and a day surgery unit.

There were 15,320 surgical admissions between December 2014 and November 2015. Of which 2,477 were elective spells (continuous stay of a patient using a hospital bed) and 8,405 day case spells and 4,426 surgical emergency admissions.

We visited all surgery services as part of the inspection. We spoke with 45 staff including staff on the wards, surgical assessment unit, day surgery unit and in theatres. We spoke with nursing staff, health care assistants, doctors, consultants, therapists, administration staff and ward managers. We spoke with 24 patients, and examined 20 patient records, including medical notes, as part of the inspection. We reviewed performance information from and about the trust.

Summary of findings

We rated surgery services as good for effective, caring and responsive and requires improvement for safe and well-led because:

The pre-operative screening process did not ensure that all patients 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.

There was confusion over the management of positive Methicillin-resistant Staphylococcus Aureus (MRSA) results following MRSA screening taken at pre-operative assessments and staff did not always follow the trusts infection control policy.

The policy for anticoagulation advice for patients was out of date on September 2014. There was no clear guidance for the management of all patients on anticoagulation who required surgery. We saw this impact on patient care. We raised this with the trust that approved new guidance in January 2016.

There was a culture of incident reporting, but staff said they did not always receive feedback on incidents submitted. Staff were unaware of never events and serious incidents that had recently occurred and no learning had been shared.

Surgery

Medicines were not always stored safely and securely to prevent theft, damage or misuse.

There was support for patients with a learning disability and reasonable adjustments were made to the service to accommodate patients with individual needs. Information leaflets and consent forms were not available in other languages. An interpreting service was available.

Medical staffing levels were appropriate and there was good emergency cover. Consultant-led, seven-day services had been developed and were embedded into the service. There was a high number of nursing vacancies; agency and bank staff were used to cover vacant shifts.

The environment was visibly clean.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Patient care records were appropriately completed with sufficient detail.

Multidisciplinary working was evident.

Appraisal levels did not meet the required target. Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs).

Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients treated with dignity and respect.

Surgical services were supported by dedicated senior staff, who were visible on the wards and theatre areas and staff appreciated this support. There was variable awareness amongst staff of the hospitals values. Staff were unaware of national audits undertaken within the hospital or of patients' outcomes relating to national audits.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

There was a culture of incident reporting, but staff said they did not always receive feedback on incidents submitted. Staff were unaware of never events and serious incidents that had recently occurred. Staff were aware of the importance of duty of candour, informing the patient when things went wrong.

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.

There was confusion over the management of positive Methicillin-resistant Staphylococcus Aureus (MRSA) results following MRSA screening taken at pre-operative assessments. Staff did not always follow the trusts infection control policy.

The policy for anticoagulation advice was out of date on September 2014. There was no clear guidance for the management of all patients on anticoagulation management who required surgery. We saw this impact on patient care. We raised this with the trust that approved new guidance in January 2016.

Medicines were not always stored safely and securely to prevent theft, damage or misuse. We observed that most medical records were stored appropriately. However, one ward used an open shelf cabinet to store medical records which meant people visiting the ward could access them. We observed the Five Steps to Safer Surgery checklists completed.

Staff had an understanding of safeguarding, but mandatory training levels including safeguarding were did not meet the trust target.

There was a number of nursing staff vacancies in surgery. Safe staffing levels were achieved by the use of bank and

agency staff. Bank and agency staff told us they had completed the hospital induction programme and had been orientated onto the ward. Medical staffing levels were appropriate and there was good emergency cover.

The environment was visibly clean.

Patients were appropriately escalated if their condition deteriorated. Nursing and medical handovers were well structured and good multidisciplinary team working was evident within the surgical wards visited.

Incidents

- Staff were aware of how and when to report incidents using the trusts Datix system (an electronic programme for reporting incidents).
- One never event was reported between January and October 2015 where a patient received the wrong blood transfusion. 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. This was categorised as a transfusion or transplantation of ABO incompatible blood components (ABO in the blood grouping system used in blood transfusions). A root cause analysis (RCA) was carried out which concluded the process and policy for training and checking of blood samples had not been followed correctly.
- Additional training for blood transfusion was implemented as part of lessons learnt. The most recent training records showed that across the trust 59% of medical and 79% of nursing staff had received training. We did not see evidence that this never event had been discussed with staff. Most staff we spoke with were unaware of this never event, despite the never event being highlighted in the quality newsletter in November 2015 which was emailed to all clinical staff.
- There had been 23 serious incidents reported within the surgical division between August 2014 and September 2015, through the Strategic Executive Information System (STEIS). There had been eight pressure ulcers and four slips, trips and falls. This information was displayed at the entrance to each ward and clinical areas. Actions taken to reduce incidents, such as slips trips and falls, included daily reviews of patient's status at handover and quality checks by senior staff implemented to ensure patients care plans were up to date.
- All serious incidents were analysed to ensure lessons were learnt. Staff within the surgical services told us they were informed of some incidents and we saw team meeting minutes which showed that incidents in surgical services had been addressed. Although, staff told us they did not always receive feedback regarding all incidents reported.
- One serious incident resulted in a patient being asked to stop their anticoagulation medication 10 days prior to surgery and a delay in re commencing the anticoagulation medication post surgery. This did not comply with the guidelines in the British National Formulary (a pharmaceutical reference book). The policy for anticoagulation for in-patientswas out of date in September 2014. This policy did not include specific guidance regarding stopping anticoagulation prior to surgery. We raised this with the trust who approved new guidance in January 2016
- 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.
- Staff understood their responsibilities with regard to the Duty of Candour legislation. The ward sisters and theatre manager described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives, and an apology given whether there was any harm or not.

Safety thermometer

- The NHS Safety Thermometer is a t Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter urinary tract infections and falls. Some of this information was displayed at the entrance to the wards, such as number of falls and pressure ulcers.

- All wards had information displayed at the entrance about the quality of the service and this included their safety thermometer results. Infection control measures, results of Friends and Family Tests, the number of complaints and the levels of staff on shift were also displayed outside each ward area. This meant patients and the public could see how the ward was performing in relation to patient safety.
- Between August 2014 and July 2015 there were four slip, trips of falls recorded in the surgical wards and eight pressure ulcers recorded.

Cleanliness, infection control and hygiene

- The wards and theatres were visibly clean and well maintained. 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.
- Staff told us they cleaned equipment after they used it.
- Hand hygiene gels were available throughout the wards and theatres. There was access to hand-wash sinks in bays and side rooms on the wards.
- On occasions patients pre-operative assessments by consultants and anaesthetists were conducted in the sisters ward office. Although alcohol gel was available, the office did not have medical equipment or a sink for hand washing.
- There was awareness among staff about infection control and we observed staff washing their hands and using hand gel between treating patients. We observed all staff using alcohol hand gel when entering and exiting wards and theatres.
- Personal protective equipment, such as gloves and aprons were used appropriately.
- Most patients for planned surgical admissions were reviewed in the pre-assessment clinics; all patients were given instructions on showering prior to admission.
- Patients attending pre-operative assessment clinics received a Methicillin-resistant Staphylococcus Aureus (MRSA) screen. This involved taking a swab to test for the presence of MRSA on patient's skin or in their nose. This followed the Department of Health guidelines on MRSA admission screening guidance for NHS 2014.
- There was confusion about the management and follow up action required by staff in pre-operative assessment if a patient tested positive for MRSA. Although there was a policy that followed national guidance, the preoperative nurse told us they received conflicting advice from the infection control team, that differed between patients. We raised this issue during our inspection, lead nurse in pre-operative assessment told us that they would clarify the action to be taken with the infection control department.
- We saw signage on side rooms indicating when a patient had an infection and the precautions needed. We observed all staff using alcohol hand gel and protective clothing when attending to these patients.
- In each ward area, staff had audited their performance to infection prevention and control measures; reports were shared with staff at meetings. The monthly audit results showed most wards and theatres were over 90% compliant with infection control practices, such as hand hygiene.
- Shand ward had recently won a local award from the infection and prevention control committee for the most improved ward on their audit scores. Staff on Shand ward were very proud of this award and this encouraged them to maintain good standards. In some areas their practice had improved by 10%, this was mainly in invasive device management.
- The trust had no reported cases of MRSA in the last 12 months.
- The trust had three cases of Clostridium difficile (C.difficle) in the last 12 months.
- The trusts 2015 Patient Lead Assessments of the Care Environment (PLACE) indicators was better than the England average. Cleanliness scored 99 to 100% across all areas.

Environment and equipment

- Resuscitation equipment in operating theatres and ward areas were checked daily and documented as complete and ready for use. These trolleys were secured with tags which were removed daily to check the trolley and contents were in date.

- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- There were systems to maintain and service equipment as required. Equipment had portable appliance testing (PAT) stickers with appropriate dates. PAT is an examination of electrical appliances and equipment to ensure they are safe to use.
- We saw that hoists and firefighting equipment had been regularly checked and serviced.
- Theatre had dedicated storage rooms for equipment and surgical instruments. These areas were clean, tidy and well-structured with sign posting and equipment lists to enable staff to access equipment quickly. There were marking and signs on the floor to store specific equipment, such as monitoring equipment and staking systems.
- Staff within the recovery unit said they had all the emergency equipment they required at hand. We observed sufficient equipment available during our visit to the recovery unit.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed. Bins were emptied regularly and we observed domestic staff wearing protective clothing when emptying bins.
- We observed patient's valuables were securely stored before their procedure in a locked cupboard on Tavistock ward. This meant that they were kept safe. However, during our inspection on Richard Wells ward we saw patients' valuables were stored in the unlocked sister's office whilst the patient was in the operating theatre. This meant that patient valuables were not always kept safe.

Medicines

- The hospital used an electronic prescribing and medication administration record system to promote the safe administration of medicines.
- Members of the pharmacy team visited the ward each weekday and were involved in all aspects of patients' individual medicine requirements. This included taking a detailed medicine history as well as checking that any prescribed medicines were correct. Any concerns about medicines or additional advice for prescribers and nursing staff were recorded on the electronic system.
- The drug cupboards within the theatre environment were left open whilst theatres were operating to allow staff quicker access to the drug cupboards, this did not include controlled drugs. A risk assessment for the storage of medication in the theatre complex had been completed which concluded that locking the cupboards may increase the risk to patients if staff did not have quick access to medicines that were in locked cupboards. Access to the theatre complex was controlled by keypad code, then swipe access to theatre, therefore only staff had access and a staff member accompanied all patients. Cupboards were locked when theatres were not in use.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. On one ward we saw that two patients, who had been admitted at the weekend, had to wait two days for their medicines to be made available. Nursing staff told us that there could be a delay in prescribing and dispensing discharge medicines. This meant that patients did not always have access to medicines when they needed them.
- Some prescription medicines are controlled under the Misuse of Drugs legislation 2001. These medicines are called controlled drugs (CDs). We saw CDs were stored and managed appropriately although the daily stock check required by the trust's policy was not always recorded so there was a risk the identification of discrepancies could be delayed.
- Temperatures in the medicines storage areas were not recorded daily in line with the trust's policy and we could not be sure that medicines, including those requiring cool storage, would be fit for use.
- Medicines were stored in locked treatment rooms, but the individual cupboards were not all locked in line with the trust's policy. We found drug cupboards open on Richard Wells ward and drugs not stored in a drug cupboard at all. We found a medication fridge unlocked and leaking water on Tavistock ward. We raised this with the ward manager who reported it immediately to estates.

- Nursing staff wore a red apron to indicate they were administering medicines to alert staff not to disturb them to prevent drug errors.
- Stocks of intravenous fluids were stored securely on shelving within locked cupboards.
- We looked at the prescription and medicine administration records for 15 patients across two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. Patient's allergies to any medicines were appropriately recorded.

Records

- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Records were legible, accurate and up to date.
- We examined 20 patients' medical and nursing records across surgical wards and theatres. There were detailed and comprehensive pre-assessments, where these had been undertaken on patients prior to admission.
- The records we reviewed showed that the World Health Organisation's Five Steps to Safer Surgery checklist had been completed. The checklist was designed to prevent avoidable harm included, the patient's identity and whether they had any known allergies.
- We were shown the audit results for the Five Steps to Safer Surgery checklist for January to October 2015 which confirmed a 99% compliance with this procedure. The theatre manager told us this was a priority within theatres to ensure all staff were engaged with the process.
- Not all patient records were stored securely in the ward areas. On the surgical wards, nursing records were held at the end of patients' beds. Medical records were usually stored in dedicated trolleys, but these were unlocked. On Richard Wells ward we found patient notes stored in open shelving near the entrance to the ward. This meant there was a risk that unauthorised people could access them. However, after the inspection the trust informed us that lockable record keeping trolleys had been sourced for Richard Wells ward.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- Staff had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- The surgical teams were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and they told us they were helpful and responsive.
- In October 2015 the overall compliance for all disciplines within the surgical directorate was 80% for level 1 safeguarding training for adults and children. This did not meet the trust target of 90%.

Mandatory training

- The electronic rostering system recorded training completed and dates required for renewal. This was used to assist with planning staff training.
- The trust's training records showed that 69%of medical and nursing staff in the surgical division had completed their mandatory training against a trust target of 90%. We were told that staff requiring training had dates planned in the future.
- There was an induction programme for all new staff. Staff who had attended this programme felt it met their needs.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained.
- Preoperative assessments were carried out on most patients. However, on one day of the inspection we observed three patients arrive on the surgical wards for surgery that had not attended pre-operative assessment clinic and did not have the relevant assessment or tests carried out in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. There was no system in place to ensure that pre-operative assessments were carried out prior to admission. If the patient did not have pre-operative MRSA or blood tests, they were carried out

on admission. There was a risk that patients that did not attend pre-operative assessment did not have appropriate opportunity to discuss the procedure and discharge arrangements. This meant that patients that did not attend pre-operative assessment were at risk of not being fully prepared both physically and emotionally for planned surgery.

- Following the inspection, the trust informed us that an additional safety check had been implemented, to track the attendance of patients. The admissions department email pre-assessment and the team checked attendance and liaised with the patient if required. A monthly audit was implemented.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- Staff we spoke with in the anaesthetic and recovery areas were competent in recognising deteriorating patients. The National Early Warning Score (NEWS) was used to identify if a patient was deteriorating and staff had attended training on how to use the tool and identify the deteriorating patient.deteriorating patient policy, NEWS There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these.
- Staff had access to the trust's critical care and outreach team for patients that had deteriorated or required additional medical input. Staff told us they were very supportive to staff on the ward and visited the patients on the wards as required.
- Patients requiring critical care and outreach team support were discussed at the hospitals quality meeting. We witnessed the outreach team offering support to ward staff and arranging to review a patient.
- There was 24 hour access to emergency surgery teams, including theatres, doctors and endoscopy.

Nursing staffing

- Nursing staff numbers were assessed using the electronic rostering tool.
- The trust performed biannual staffing reviews for all wards including surgical wards. The Safer Nursing Care Tool, Professional Judgement, Care Contact Time along with benchmarks against the minimum staffing levels were used to allocate staffing numbers.
- Senior staff told us the most recent staffing review was undertaken in June 2015 and this showed that all of the surgical wards were staffed appropriately. The next review was due January 2016.
- The planned and actual nursing staffing numbers were displayed on the wards. Staffing levels were appropriate to meet patients' needs during our inspection.
- Daily meetings were held with matrons and senior nurses to review staffing levels and skill mix. We observed effective communication at these meetings and deployment of staff to other wards to maintain patient safety. Future planning of staffing levels and patients' requirements was also discussed.
- At the time of our inspection, vacancy rates for registered nursing positions within the surgical division was 10% and for unregistered nurses was 6%.
- Staff in both surgical wards and theatre said they recognised recruitment was a major safety risk to the service. This was captured on the trust risk register.
- The management team told us of various measures they had undertaken, such as overseas recruitment initiatives, to decrease the vacancy factor. Staff were aware of these initiatives and were supportive of them.
- Vacancies were filled with bank and agency staff. The sisters told us they requested the same agency staff to ensure continuity within the wards. Agency staff spoken with confirmed this. Bank and agency staff within the surgical wards told us they were orientated to the ward and aware of where equipment was stored and how to access information.
- Additional bank rates were offered to permanent staff to encourage them to work available shifts. If staff had a period of sickness, they would not be offered additional shifts for two weeks to allow them to recover from their sick episode.
- Tavistock ward was last opened overnight in June 2015 to four surgical patients. The ward was staffed with

permanent staff and bank staff from other surgical wards to ensure they had the relevant competencies to care for these patients. These shifts were then filled with agency.

- Nursing handovers occurred at the change of shift. We observed the handovers on three wards, Shuttleworth, Richard Wells and Shand ward. The handovers occurred at the patient's bedside which meant that patient privacy, dignity and confidentiality were not always maintained as other patients or visitors in the bay could hear the conversations. We raised this with one ward manager at the time of the inspection, who planned to discuss this at the sister and matrons meetings.
- The handovers were well structured and used electronic information sheets. The information discussed included patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and on-going care. During handover patients' specific needs were discussed and updated, such as falls assessment and dietary needs.

Surgical staffing

- The records provided by the trust showed that the medical staffing levels were 37% for consultant cover which was lower than the England average of 40%. Middle career group (doctors who had been at least three years as a junior doctor or a higher grade within their chosen speciality) was at 10% which was just lower than the England average of 11%. Registrars were 34% which was lower than the England average of 37%, whereas junior doctors were 19% which was higher than the national England average of 12%. However, the doctors and consultants said they had sufficient cover for their specialities. Staffing levels were appropriate to meet patients' needs during our inspection.
- At the time of our inspection, vacancy rates for medical positions within the surgical division was 6%. Locum doctors were used to fill vacancies.
- Junior doctors had specific personal development plans and junior doctor handbooks. They told us they felt supported and the consultants were accessible, approachable and available when required.
- Doctor's ward rounds occurred daily and this involved nursing and allied health professionals, such as physiotherapists.
- We observed doctors' surgical ward rounds on Shuttleworth ward and surgical assessment unit (SAU) which were well organised and structured. There was good interaction between doctors and nursing staff. Nursing staff were encouraged to be part of the doctors ward rounds to ensure on going care was planned and agreed.
- Surgical consultants worked weekends and carried out ward rounds to ensure that there was provision of consultant led care and decision making. There was consultant cover for emergency's 24 hours a day.
- There was a trauma and orthopaedic consultant on call seven days a week to be available for any emergencies.
- There was a dedicated orthogeriatrician to support patients with a fractured neck of femur. Orthogeriatricians aimed to visit patients on the ward on the day of admission to assist with care planning.
- Doctors carried participated in the daily multidisciplinary team meetings to discuss patients care.

Major incident awareness and training

- The hospital had a major incident plan that was up to date, which included information on how to deal with incidents such as flood, pandemic flu and severe weather. There were specific cards with clear specific roles for staff to undertake during a major incident.
- Staff knowledge regarding major incidents was limited within the surgical areas, staff told us they would refer to the online policy and call senior staff if this occurred.
- Some staff told us a desk top simulation of major incidents had recently taken place.
- Staff were aware of fire drills and had been involved in these simulations.

Are surgery services effective?

Good

We have rated effective as good because:

Surgery

The trust participated in national and local audits, for example the Patient Reported Outcomes Measures (PROMs) which overall showed the trust was matching results seen nationally in PROMS for hips and knees, groin and varicose vein surgery. The National Hip Fracture Database audit showed the trust performed better than the England average in three of the seven measures.

Policies and procedures were accessible, and staff were aware of the relevant information. Care was monitored to demonstrate compliance with standards. Patient's pain, nutrition and hydration were appropriately managed.

Patients were asked for their consent to procedures appropriately and correctly. Most staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs).

Staff worked in multidisciplinary teams to co-ordinate patient care. Annual appraisals showed that staff did not meet the trust's target of 90%. This meant that there was a risk staff did not have the necessary skills to meet patient needs.

The surgical service had a consultant-led, seven day service.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was planned and delivered in line with evidence based guidelines for example nutritional and hydration needs, falls assessment and national infection control guidance.
- Local policies, such as the pressure ulcer prevention and management policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- Policies and guidelines were readily available on the trust's intranet. These were seen to be up to date. Policies followed guidance with National Institute for Health and Care Excellence (NICE) and other professional associations for example, Association for Perioperative Practice (AfPP).
- The trust participated in the National Hip Fracture Database (NHFD) which was part of the national falls and fragility fracture audit programme. The trust performed better than the England average in three of the seven measures. The trust scored well against the standards 'mental test score recorded on admission', patient 'received falls assessment', and patient 'received bone health assessment'. Comparing to all trusts, this trust's result for perioperative assessment was in the lowest 25% of all trusts' scores; all other results were within the middle 50% of trusts. We saw an action plan in place to improve the care of patients with fracture femurs.
- Venous thromboembolism (VTE) assessments were clearly recorded on the electronic drug charts, ensuring best practice in assessment and prevention.
- Senior staff on the admission ward told us that sometimes patients were cancelled on the day of the operation due to further investigation being required. However, the trust reported that there had been no patient surgery cancelled as a result of lack of pre-operative assessments beforehand. This meant that we were unable to clarify numbers if patients this may have affected.

Pain relief

- Pain was assessed and managed effectively.
- Patients' records showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner. Pain management for individual patients was discussed at handovers as required.
- An audit between February and March 2015 assessed pain management of 50 surgical patients. The results showed 100% of pain scores were recorded, 96% of patients with pain had appropriate actions taken and 92% of patient's either satisfied or very satisfied with their pain relief, and felt that staff had done everything they could to control their pain.
- A nurse specialist in pain control was contactable by telephone for advice and would assess a patient if asked.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. If a patient was at risk of malnutrition they were referred to a dietician.
- In 20 records we reviewed, fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken where required. The care support staff assisted patients with menu choices and ensured dietary needs were met.
- The surgical wards had protected meal times, to ensure patient had their meals when they were warm and were not disturbed. We observed staff implementing this by ringing a bell to alert visitors to the ward to the beginning of protected meal times, some visitors were asked to leave the bays during this time. This meant that staff were available to help serve food and assist those patients who needed help. We observed good interaction between staff and patients to encourage patients to eat their meals.
- We observed there were 'red trays' and red cups to identify patients who needed help with eating and drinking, including when patients were at risk of malnutrition or dehydration.
- There were additional drinks, snacks and yoghurts available on the wards.

Patient outcomes

- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMs) programme and the National Joint Registry (NJR).
- Overall, the trust matched results for patient outcomes of health following surgery seen nationally in PROMs for hips and knees, groin and varicose vein surgery.
- Data from the National Hip Fracture Database 2015 showed the trust performed better than the England average in three of the seven measures. The trust scored well against the standards 'mental test score recorded on admission', patient 'received falls assessment', and patient 'received bone health assessment'. Compared with all trusts, Bedford Hospitals result for perioperative assessment was in the lowest 25% of scores; all other results were within the middle 50% of trusts. We saw an action plan in place to improve the care of patients with fracture femurs.
- The risk of readmission ratio was 86 for elective surgery and 82 for non-elective surgery. This was better than the national average ratio of 100. This meant that following surgery patients were at a lower risk of readmission than other hospitals in England.
- Data from the National Bowel Cancer Audit 2014 showed good performance. The trust performed better than the England average for each of the three measures.
- Data from the National Emergency Laparotomy Audit 2015 showed the trust had mixed performance. The audit rates performance on a red-amber-green scale, where green is best. The trust had three green results related to consultant presence in theatre. Performance against the measure 'Arrival in theatre in timescale appropriate to urgency' was also rated green. The trust rated red against three measures: 'Risk documented preoperatively', 'Direct postoperative admission to critical care', and 'Assessment by a medical consultant for the care of older people specialist in patients over 70 years'. The remaining three measures were rated amber. The trust had reviewed the documentation of risk and assessment for admission to critical care, on the basis of our inspection and a new policy was drafted at the end December 2015.
- Patients considered their outcomes as good. One patient said "I know I'm in safe hands" and another said "staff do rounds every day, I know what is going to happen next and they are planning my discharge".

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. For example, there was a specific induction programme for staff. Staff that had attended the induction programme told us this was useful. The induction programme included orientation to the wards, specific training such as fire safety, infection control and manual handling as well as awareness or policies. Nursing staff (both agency and permanent) felt well supported and adequately trained in their local areas.

Surgery

- Junior doctors within surgery all reported good surgical supervision, which they felt enhanced their training opportunities. Junior doctors told us staff were flexible in changing shifts to accommodate training needs, which included personal development plans and a generic junior doctor's handbook. Junior doctors told us they felt supported and the consultants were accessible, approachable and available when required.
- The records for October 2015 showed that within surgery, 59% of all staff had received their appraisals against a target of 90%. We saw the appraisal rate for consultants as of November 2015 was 62% which was below the trust target of 90%. Some staff told us they had appraisals booked in the near future.
- Staff said they had not received regular clinical supervision. The ward sisters confirmed they were aware of the shortfall and were reviewing the way they could arrange supervision. Matrons and ward sisters had regular meetings which included some clinical supervision.
- Staff within surgery had completed mandatory training which included Mental Capacity Act 2005 (MCA) and, Deprivation of Liberty Safeguards (DoLS), which was 87% compliant, against a trust target of 90%.

Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors and physiotherapists.
- There was good multidisciplinary working within the wards to ensure patient care was coordinated and the staff in charge of patients' care were aware of their progress. We saw physiotherapists and occupational therapists assessing and working with patients on the wards, then liaising with and updating the nursing and medical staff.
- Staff said that they could access medical staff when needed, to support patients' medical needs. For example we saw a patient on one ward whose condition had deteriorated and doctors were called to review the patient's condition. We saw a quick response and good interaction between nursing and medical staff.
- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us they felt supported and that their contribution to overall patient care was valued.
- We tracked a patient's journey from the admissions to theatre. We saw good interaction between the admissions team and theatre staff which included the handover of the patient's notes.
- We observed senior staff at the daily operational and quality meeting sharing information about patients' needs and staffing levels. Senior staff offered support and moved staff with specific skills from one ward to another to support patient needs.
- Staff could access the learning disability lead, critical care team, pain management team, social workers and safeguarding teams who were able to provide advice and support to the surgical teams.
- We observed the theatre staff working well together as a team, discussing patients' needs, equipment required and planning for the theatre lists.

Seven-day services

- Patients had access to consultant cover seven days per week and other support services, such as pharmacy, physiotherapy and theatres were available if required.
- Consultants carried out daily ward rounds including the weekends on all surgical wards.
- Emergency theatres were available seven days a week and additional staff were on call, if extra staff were needed to manage emergencies.
- There was no out of hours occupational therapy cover, therefore patients did not receive occupational therapy at the weekends, which may impact on their care. Nursing staff told us they helped patients with their daily needs such as dressing and walking when occupational therapists were unavailable.
- Physiotherapists were available at weekends, they would visit each surgical ward to offer physiotherapist support.
- Staff told us they had access to imaging, pathology and endoscopy out of hours. Pharmacy also provided an out of hour's service and they were open at weekends.

Access to information

- Staff had good access to patient-related information and records whenever required. There were computers throughout ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff said that when a patient was transferred from for example; SAU to a ward, they had access to patient information. Staff said they were given a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.
- Discharge summaries were dispatched by the medical secretaries to GP's.
- Ward staff told us they had link nurses for specific areas, for example, learning disability and infection control. The link nurses were able to support staff and share information.
- We observed on-going care information was shared appropriately at handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements and guidance. The trust had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures not under a general anaesthetic.
- All consent forms we saw were fully completed for patients who were able to consent to their operation/ procedure (forms contained details of the operation/ procedure and any associated risks). Patients were able to have a copy of the form if they wanted.
- The consent process generally occurred in out-patients or on the day of surgery.
- We observed the consent process which was clear, accurate and informative for the patient, and that correct site surgery was marked at the time.
- Patients confirmed they had received clear explanations and guidance about the surgery, and that they understood what they were consenting to.
- Staff told us they had annual training for MCA and DoLs. Staff within surgery had completed mandatory training which included Mental Capacity Act 2005 (MCA) and, Deprivation of Liberty Safeguards (DoLS), which was 87% compliant, against a trust target of 90%.
- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLs for patients and when these needed to be reviewed.

Are surgery services caring?

Good

We rated caring as good because:

Staff were caring and compassionate to patients' needs. Staff treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support, to enable patients to access services.

Patients and their relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied health professional staff. The staff on the wards and in theatre areas respected confidentiality, privacy and dignity. We observed good emotional support to a family on Shuttleworth ward.

Patients were kept up to date with their condition and how they were progressing. Information about their surgery was shared with patients, and patients were able to ask questions. Relatives were able to be involved in these discussions.

The hospital encouraged the Friends and Family Test and carried out a patient satisfaction survey.

Compassionate care

- We saw that patients were treated with dignity, respect and compassion when they received care and support from staff.
- We saw results of the Friends and Family Test displayed at the entrance to each surgical ward.The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received.

- We saw that the response rate varied across the service. The response rate for Friends and Family Test in surgical wards was slightly worse than the national average of 36% with a response rate of 33%. In October 2015 the surgical wards Friends and Family Test showed the following results, Richard Wells 94%, Shand 91%, Shuttleworth 82%, Tavistock 100% and SAU 100% of patients would recommend the hospital to family and friends.
- We saw nursing staff introduced themselves appropriately and knocked on the door of side rooms before entering.
- We received positive comments from the vast majority of patients we spoke with about their care. Examples of their comments included "I know I'm in safe hands", "Nothing is too much trouble for staff", and "Feels like you are being cared for by your family. Staff are very kind".
- The trust carried out a patient satisfaction survey, within the surgical wards between March and August 2015. The results were generally positive with over 90% of patients satisfied with aspects of their care including, they felt listened to, treated with respect and were involved in decision making.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. Patients had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of their condition. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- Patients and those close to them were involved as partners in their care and able to seek further information about their operation or procedure from staff.
- We observed most nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Patient records had individualised care plans, which involved the patient in their planning.relatives was maintained throughout the patient's care.
- We observed a patient admitted to Tavistock day ward and their relative was able to stay with them during the admission process, to ask questions and be involved in their care.

Emotional support

- 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.
- Staff carried out daily quality checks at handovers to ensure care plans were up to date and patients' needs had been assessed including emotional and mental health needs.
- Staff said that assessments and support was generally available for patients from mental health practitioners.
- On Shuttleworth ward we observed a family offered emotional support and privacy with a patient whose condition had deteriorated. The nursing staff spent time with the family, offered drinks and called the doctors to meet with the family when they arrived onto the ward.
- The trust employed a lead chaplain, a part time Roman Catholic chaplain and a team of locums to provide a 24 hour, seven day a week chaplaincy service. There were chaplains for the Muslim, Sikh and Quaker faith with plans to recruit to Buddhist and Jewish faiths. Twelve lay chaplaincy visitors and voluntary teams provided a Sunday act of worship.

Are surgery services responsive?

Good

We rated responsive as good because:

National 18 week targets for referral to treatment times (RTT) in surgery (admitted pathway) were met in five of the eight specialities in surgery between January 2014 and June 2015. Generally, the trust performed better than the England average for RTT.

Surgery

The average length of patient stay for both elective and non-elective patients was similar to the England average.

An interpreting service was available. Information leaflets and consent forms were unavailable in other languages.

Patients reported that they were satisfied with how complaints were dealt with.

The admission process on Richard Wells ward was not effective, patients waited in a converted ward kitchen and there were no dedicated room for admission or to get changed for theatre. All patients for surgical admission arrived at the same time, which meant that some patients incurred long waits and privacy and dignity was not always maintained. The hospital did not offer staggered admissions.

Service planning and delivery to meet the needs of local people

- The trust's main commissioning Clinical Commissioning Group (CCG) was NHS Bedfordshire CCG and the trust provided monthly reports on quantitative and qualitative data to the CCG.
- Bedford Hospital was the vascular hub for Bedfordshire, Luton and Dunstable, and Milton Keynes. Vascular services were available 24 hours a day. Patients requiring elective vascular surgery were reviewed by an anaesthetist at the pre-operative assessment clinic.
- The service monitored the use of its theatres to ensure that they were responsive to the needs of patients. The average theatre utilisation during 2015 was 64%, which indicated that theatre were not fully utilised. Theatres were open on a Saturdays for elective cases and emergency cases to meet the needs of local people.
- Matrons undertook daily and weekly review of patients who were coming into hospital to ensure bed availability to meet their needs.

Access and flow

- Between January 2014 and June 2015 the percentage of patients waiting less than 18 weeks from referral ranged from 83.3% to 92.5%. The target of 90% was met for two of these months. The trust did however, perform better than the England average for 14 of the months (78%).
- The percentage of 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% if patients. This meant that some trauma and orthopaedics patients waited longer than expected to start treatment.
- 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 withthe national standard.
- The trust participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme. Between April 2014 and August 2015, 75% of patients with a fractured neck of femur had surgery within 24 hours of admission, which was the same as the national average. The length of stay in hospital was 16 days, which was in line with the national average.
- Between October 2014 and September 2015, 179 patients had their operations cancelled and six (<1%) were not re booked within 28 days. This was better than the England average.
- The average length of patient stay for both elective and non-elective patients was similar to the England average for July 2014 to June 2015. The average length of stay for non-elective vascular surgery patients was slightly longer than the England average (14 days compared to 12 days). However, the longer stays may be a reflection of the admission of complex patients due to the hospital being the vascular regional hub.
- Some surgical patients remained in recovery up to five hours. They were monitored by both recovery staff and the critical care outreach team prior to returning to the ward or being admitted to the critical care centre (CCC). We saw the Physiological and Operative Severity Score for the enumeration of Mortality and Morbidity (POSSUM) utilised by surgeons to assess and monitor the severity of risk to patients. We saw patient risk was responded to appropriately. However, doctors confirmed they transferred very few surgical patients to CCC due to discharge delays caused by the poor availability of wards beds and therefore, patients remained longer on CCC that required.
- Patients were admitted to Tavistock day ward for day surgery and initially for longer in-patient admissions.

The patient for overnight stay would be admitted to Tavistock ward initially then be transferred to one of the surgical wards after their operation if they required to stay overnight and longer periods.

- Patients were not given a specific admission time, therefore all patients arrived at the same time, some with relatives. We observed many patients arriving at the same time and there were queues to check in at reception desk and people standing in the waiting areas.
- Patients admitted to Richard Wells ward also all arrived at the same time. The admission process appeared disorganised as the patients were admitted into a converted kitchen area and taken to several different rooms to be seen by the consultant or anaesthetists. There were two designated rooms, but often these were in use due to so many patients arriving at the same time.
- Nursing staff on Richard Wells ward told us they did not always know the whereabouts of all patients who were waiting for surgery as there were several assessment rooms patients could be in.
- The consultant and anaesthetist saw patients prior to their operation. Once patients had seen the consultant and anaesthetist, they could wait for hours in the converted waiting room. We spoke with one patient who had waited for six hours, they told us it was an early start to the day and a long wait, which was boring. Another patient told us they did not mind waiting as long as they could have their operation the same day.
- Relatives were not encouraged to wait with patients as the waiting area could not accommodate high numbers of people. The hospital did not offer staggered admission times for patients to prevent long waits.
- Patients were kept up to date of waiting times and patients waiting long times were offered water if appropriate.
- The patients for overnight and longer hospital stays were transferred to the surgical wards direct from theatre after their operation had taken place.
- When patients were called to go to theatre they got undressed in the wards main bathroom at the end of the bay as there were no designated changing areas. We observed one patient in a theatre gown getting onto a theatre trolley in the main corridor as there were no designated rooms. There was a risk that patient's privacy and dignity was not maintained.
- On occasions Tavistock day ward was opened overnight to accommodate patients overnight to relieve bed pressures across the hospital. A risk assessment was carried out and escalation plan implemented for this process.
- Staff on Tavistock ward told us that there could be delays in admitting day surgery patients if patients had been admitted overnight to the ward. This was because of lack of space to accommodate day case patients and not enough staff available to care for both the inpatients and the day case patients.
- Since January 2015 one patient had been nursed overnight in the trust's theatre recovery area. The patient was post-operative and required a bed on the critical care complex. The trust ensured the patient's needs were fully met at all times by ensuring that a dedicated recovery nurse was available for the continuation of care whilst in the recovery area until a bed became available on the critical care complex.
- Some patients were discharged directly from the ward and others waited in the discharge lounge, if they were waiting for medication to take home or transport. The nurse would discuss discharge arrangements, such as visits by the district nurses, or physiotherapy and follow up appointments. Patients were given a copy of the discharge letter that was sent to the GP and relevant information leaflets, such as post-operative care.

Meeting people's individual needs

- Staff told us they had access to translation services in person or via the telephone system. However, there were no patient information leaflets available in different languages.
- Patients who attended the pre-operative assessment clinic were given information leaflets such as, preventing thrombosis and fasting instructions.
- From the patients satisfaction survey between March and August 2015, only 43% of patients felt they were given enough written information about their procedure.

- Bariatric equipment could be hired if required.
- We saw 'this is me' document in patient records, completed by relatives appropriately. This helped staff to meet the specific needs of patients living with dementia.
- Staff and patients reported they did not have mixed sex bays on surgical wards, we did not find any evidence of mixed sex bays.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with concerns directly.
- Information was available in the main hospital areas, such as literature and posters, about how to raise formally or informally a concern or complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- During October 2014 and September 2015 there had been 165 complaints within surgery. Most related to poor communication, issues with the admission process and discharge process, and some aspects of care. Complaints were generally responded to within 45 days. We saw actions taken in response to complaints, such as specific discharge information sheets implemented to improve the discharge process.
- None of the patients we spoke with had any complaints. Several patients said they were aware of how to complain if they needed to.
- The ward sisters received all the complaints relevant to their service and gave feedback to staff regarding complaints in which they were involved.
- Staff told us that some verbal complaints were managed on the wards or in theatres, and were not always reported. Staff told us these complaints were dealt with as soon as they occurred by either the ward sister or matron. This meant that some complaints were concluded at service level, but staff were unaware of outcomes, themes or lessons learnt.
- Written complaints were managed by the matron and at directorate level. A full investigation was carried out and a written response provided to patients. Outcomes, lessons learnt and actions were not always cascaded to the staff within the wards or theatres.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement because:

Leaders within the surgical division told us that due to the healthcare review within Bedfordshire it was difficult to produce a long term strategy or vision for the services, as they were unsure of the future provisions. Some senior staff and directorate leaders within surgery were unaware of trust audits and national guidance.

We saw evidence of some learning from incidents, but not from the never event or serious incidents, where action plans had not been implemented fully to reduce the risk of reoccurrence.

Not all junior staff on the surgical wards and within theatres knew who the chief executive officer (CEO) or the director of nursing and patient services (DoN) and felt their presence was minimal.

The service had regular divisional board meetings with representation from all areas of surgery including consultants, matrons, and theatre managers. Matrons and ward sisters also had meetings to discuss quality indicators, such as staffing levels, patients' safety concerns and bed occupancy.

A number of staff we spoke with had been working at the trust for many years and said it was a good place to work.

Vision and strategy for this service

- Leaders within the surgical division told us that due to the healthcare review within Bedfordshire it was difficult to produce a long term strategy or vision for the services, as they were unsure of the future provisions. Staff said they felt in 'limbo' about the health economy and review within Bedfordshire.

- We saw the surgical division business plan for 2014/15 which included increasing theatre utilisation, implementing theatre management system and meeting 18 weeks targets.
- We saw the trust's values on display within the wards, which were valuing people, leadership, respect, honesty and excellence. Not all staff were aware of the trusts values.

Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risks and to inform the executive board of key risk and performance issues.
- Clinical leaders in the division told us they had oversight of all incidents and met with matrons and ward sisters to discuss these. We saw minutes of these meetings where incidents and complaints were discussed and some lessons learnt, such as specific discharge information sheets implemented to improve the discharge process and pharmacy opening longer hours to ensure patients had their medication to take home.
- Although we did not see evidence that learning from the never event and serious incidents had been cascaded to all staff and that the specific actions had been implemented. For example, following the never event when a patient received the wrong blood transfusion the action was to increase training for staff but this was still relatively low at 59% for medical staff and 79% for nursing staff. Therefore, we were not assured that leaders within the division had implemented actions to reduce the risk of reoccurrence.
- The service had regular divisional board meetings with representation from all areas of surgery including consultants, matrons and theatre managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed.
- Mortality and morbidity meetings occurred monthly across the surgical specialities. 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.
- The trust informed us they did not consider the risk of patients not attending pre-operative assessment as a risk, therefore it did not feature on the risk register. However, after our inspection, the trust implemented measures to reduce the risk to patients not attending pre-operative assessment.
- Matrons and ward sisters also had meetings to discuss quality indicators, such as staffing levels, patients' safety concerns and bed occupancy. However, this did not appear to cascade to the wards and theatre staff. Band 5 nurses unclear of their specific quality indicators such as staffing levels, sickness, safety thermometer information, Friends and Family Test data and complaints.
- Staff said they received information regarding serious incidents but did not receive feedback on all incidents they had raised.

Leadership of service

- Surgical services were led by a divisional director, divisional medical director and divisional lead nurse, with clinical directors assigned to specialty groups.
- Not all junior staff on the surgical wards and within theatres knew who the chief executive officer (CEO) or the director of nursing and patient services (DoN), and felt their presence was minimal on the wards. During our inspection an executive team member visited the ward but three nursing staff were unable to tell us who the executive team member was.
- There are a number of initiatives used by executive directors to communicate and connect with staff. This included for example, weekly communication from the CEO, DoN or Medical Director, notice boards in the main hospital corridors with photographs of executive board members and ward visits by members of the executive.
- Some senior staff and directorate leaders within surgery were unaware of trust audits and national guidance requirements such as anticoagulation management, PROMs and Guidelines for the Provision of Anaesthetic Services.
- Junior surgical doctors reported consultant surgeons as supportive and encouraging. Junior doctors told us they felt well supervised by consultants.

Surgery

- Theatre staff told us that following reconfiguration in June 2015 within the anaesthetic department, communication, morale and working together as a team had improved.
- Each ward had a matron and ward sister who was visible on the wards and provided day-to-day leadership to members of staff on the ward. Staff on Shand and Shuttleworth wards said their matron was always visible and available to staff.
- The junior nursing staff on all wards were unanimous in stating that their immediate nursing support was good, and there was clear leadership from ward sisters and matrons.
- We observed the theatres were well managed with good leadership. Theatres had some clear objectives which included employing a dedicated education lead, a review of the Five Steps to Safer Surgery checklist to prevent duplication and to review the handover process within recovery. Staff we spoke with in theatres were aware of these objectives.
- There was general agreement from management and staff in the wards and theatres that recruitment and retention of nursing staff was seen as a priority by the trust.

Culture within the service

- Staff were enthusiastic about working for the trust and felt they were respected and valued by the management.
- We spoke with a number of staff who had worked for the trust for over 10 years and all said they felt part of the team and enjoyed working at Bedford Hospital.
- Across all wards and theatres staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. However, they felt that this could not always be given, due to the work load, shortage of staff and pressure of work.
- Senior managers said they were well supported and had effective communication with the executive team.

Public engagement

- Patients were able to feed back their views on the wards via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family. We saw results of these on display in the wards. The overall response rate of 33% showed 84% to 100% of patients would recommend the hospital to their friends and family.

Staff engagement

- Staff were encouraged to share their views at their team meetings.
- Most staff were aware of the healthcare review within Bedfordshire that was ongoing and were aware of the potential impact this may have.

Innovation, improvement and sustainability

- The hospital offered Endovascular stent-grafts for popliteal aneurysms, which is an alternative method to open surgery, early indications 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 hospital produced a SAFE chart which had amalgamated a number of nursing charts together to prevent duplication and easy access to information.

Critical care

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

Information about the service

The critical care complex (CCC) is a 10-bedded unit with a mixture of level 2 and level 3 critical care beds, which are allocated according to demand. Level 2 beds are for patients who need higher levels of care and more detailed observation and/or intervention. These patients may have a single failing organ system or require postoperative care. Level 3 beds are for patients who need advanced respiratory support, or basic respiratory support together with the further support of at least two organ systems. Level 3 includes complex patients needing support for multi-organ failure.

Consultant anaesthetists / intensivists with extensive critical care experience staff the CCC. The nursing team consists of a matron, team managers, team leaders, staff nurses, a practice development nurse and clinical support workers. Other professionals working within the service include a unit administrator, physiotherapists, pharmacists and dieticians. There is a resident doctor under the supervision of a consultant at all times. Critical care also supports nursing, midwifery, operating department practice and medical students for training as part of their courses.

During our visit to the hospital, we talked with two patients, one relative and 23 staff members. These included nursing staff, student nurses, junior and senior doctors, physiotherapists, pharmacists, dieticians, housekeeping staff and managers. We attended three handovers, which included the medical, staffing and critical care outreach teams. We also observed care and treatment and looked at seven patient records. Before the inspection, we reviewed performance information from, and about, the hospital.

Critical care

Summary of findings

Overall, we rated the critical care services as good.

We judged the safety of critical care services as good. Staff on the critical care complex (CCC) knew how to use the trust's online incident reporting system and did so. All serious incidents were analysed and discussed at weekly meetings.

The environment was visibly clean and staff followed the trust policy on infection control. Medical and nurse staffing levels was appropriate and there was good emergency cover.

There was good compliance with regard to mandatory training.

The critical care outreach (CCO) team provided 24-hour support to the risk of deteriorating patients outside of the CCC. The CCC assessed and responded to patient risk such as the review of patients admitted.

Critical care services were effective. The treatment and care provided followed current evidence-based guidelines. The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC). Data from audits showed there were good outcomes for patients treated in the critical care services.

Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We found critical care services to be caring. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients received good care, compassion, dignity and respect. We observed patients received good emotional support.

We rated responsive as requires improvement. Flow out of the CCC posed problems and many patients' discharge exceeded the recommended discharge time of four hours. ICNARC dated from March to June 2015 showed that the CCC had more delayed discharges (more than four hours) than similar intensive care units. Due to the delay in discharges, the CCC often breached the same sex guidelines. They completed the national forms in relation to sex breaches but did not complete an incident report for sex breaches. However, monitoring data demonstrated that the trust had no issues with flow into the department.

Patients discharged to the ward had follow-up support from the CCO team.

The CCC did not have psychological support for patients, relatives or staff. This had been identified as a recommendation by the Guidelines for the Provision of Intensive Care Services (GPICS) standard report for 2015.

Patients discharged from CCC did not have access to follow-up clinics. This contravened NICE guidance 83. Senior staff described the business plan they wished to implement regarding follow-up clinics.

The records did not identify patient documentation regarding the time and decision to admit to CCC. Staff confirmed they did not record the data. This meant the unit did not know if they were meeting the four-hour target of the decision to admit. However, the trust responded following feedback and amended its electronic patient record system to record this information.

Staff understood the procedures regarding complaints. However, they said that any complaint received would firstly be resolved locally. If a local resolution was not achievable, the trust's complaints service was available to patients and their families/representatives. This meant that the outcomes, themes or lessons learnt were not cascaded to staff on all complaints received.

Patients' relatives said they were involved and kept informed. There was good awareness of the needs of people living with dementia, learning disability or mental health needs. They had access to the allied mental health professional (AMHP) and liaised closely with them.

We rated the critical care service as good for well-led. A clear vision for the future of the critical care service team was not evident. Senior management said there was not a strategy for critical care and wished to implement the trust wide strategy prior to reviewing the CCC's strategy.

Critical care

The critical care bi-monthly minutes for mortality and morbidity did not have a systematic review of all mortality and morbidity within the unit. There were no actions identified with no time scales attached.

Senior staff and clinicians attended critical care governance meetings. Discussed at governance meetings were the risks to the service and significant events in other areas of the hospital. There were identified actions and who would be responsible for them.

Staff said the recent reconfiguration of the service had improved morale. The staff survey reflected this.

Are critical care services safe?

Good

We rated the safety of critical care services as good.

Staff on the critical care complex (CCC) knew how to use the trust's online incident reporting system. All serious incidents were analysed and discussed at weekly meetings. The environment was visibly clean and staff followed the trust policy on infection control.

Medical and nurse staffing levels on the CCC were appropriate which we saw were in line with relevant guidelines.

We saw the CCC risk register had recognised the failure to recruit to CCC nurse vacancies. We saw the controls and actions in place to recruit staff to the CCC.

We observed during handovers that there were clear guidance and review regarding the administration of medicines.

There was good compliance with regard to mandatory training.

The critical care outreach (CCO) team provided 24-hour support to the risk of deteriorating patients in other areas of the hospital. The CCC assessed and responded to patient risk. Examples included the introduction of the National Early Warning Score (NEWS) system and the review of patients admitted within 12 hours by a consultant.

Incidents

- There had been no 'never events' within the critical care service between August 2014 and July 2015. 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.
- Between August 2014 and July 2015 there were three serious incidents reported through the Strategic Executive Information System (STEIS). Two were unavoidable grade three pressure ulcers and one related to a diagnostic incident.

- All serious incidents were analysed to ensure lessons were learnt, for example; the review of pressure ulcers for patients.
- There was evidence of escalation to appropriate managers and the actions taken.
- We saw the implementation of SSKIN care bundles to patients admitted onto the CCC. SSKIN is a five-step model for pressure ulcer prevention.
- There were 159 incidents reported by CCC between September 2014 and August 2015. The largest category of incidents related to pressure ulcers (19). Nine of which were acquired in the community or at another hospital. Of the remaining 10 hospital acquired pressures ulcers, two were found to not be pressure ulcers following investigation.
- We saw the investigation findings and lessons learnt which included; one to one observation of patients at risk of falling and patients who had a tracheostomy or endotracheal tube being turned by a minimum of three nurses.
- Staff on the CCC knew how to use the trust's online incident reporting system. They knew they needed to report incidents such as patient falls, equipment errors, medicine errors, and out of hours admissions and discharges to and from the unit (between the hours of 9:59pm and 7am).
- Team meeting minutes provided staff with information on serious incidents. Copies were on display within the staff room.
- The CCC participated in bi-monthly mortality and morbidity meetings. However, the meetings minutes did not have a systematic review of all mortality and morbidity within the unit. There were no actions identified with no time scales attached.
- A pharmacist told us they were informed of any reported medicine or pharmacy related incident that occurred on CCC, so they could support or offer advice.
- 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.
- Staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- The legislation requires an organisation to disclose and investigate mistakes, and offer an apology if a mistake had resulted in a severe or moderate level of harm.
- Staff described a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm. We saw a flowchart within the unit, accessible to all staff, with information about the duty of candour regulation.

Safety thermometer

- NHS Safety Thermometer results between July 2014 and July 2015 showed the service had two category two to four pressure ulcers, one fall with harm, and one catheter-associated urinary-tract infection.
- The CCC had adapted and developed safety crosses relevant to the service. These were on display on the walls of the unit for staff, visitors and patients to see. Examples included; medicine errors, discharges to ward between 9:59pm and 7am and re-admission within 48 hours. We saw there had been one medicine error and no discharges out of hours or re-admissions during November 2015.

Cleanliness, infection control and hygiene

- The CCC visited was visibly clean, with the appropriate green 'I am clean' sticker visible on the equipment used. We saw completed cleaning schedules in use throughout the unit.
- Hand hygiene gels were available outside the unit and side rooms. Hand-wash basins were also available in bays and side rooms.
- The entrance to the unit displayed instructions and advice on infection control. This informed patients and visitors how to prevent and reduce infection. We observed visitors using the hand gel prior to visiting the unit.
- There was awareness among staff about infection control and we observed staff followed the trust policy on infection control, which included the washing of hands and the use of hand gel between treating patients. There was adherence to 'bare below the elbow' policy in clinical areas. Personal and protective

equipment, such as gloves and aprons, were available in sufficient quantities. This met the National Institute for Health and Clinical excellence (NICE) guidelines (QS61 Statement 3).

- The unit completed monthly hand hygiene audits and the unit had a continuous score of 98% from September to December 2015.
- The information board indicated that there had been no Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia or cases of Clostridium difficile (C.Diff) on CCC between September and December 2015. Data reported by the CCC to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) showed that there had been no unit-acquired infections between April and June 2015 (reported September 2015).
- There were side rooms available on the CCC that had adjustable air pressures to isolate patients if required for infection control and prevention reasons. There were no issues or concerns reported during our visit.
- The unit had cleaning schedules with daily cleaning duty allocations. We saw these were on display within the ward.
- The infection prevention and control annual report for 2014/15 identified the presence of pseudomonas aeruginosa within the CCC. The CCC had yielded positive results from various outlets since testing commenced in January 2013. Pseudomonas aeruginosa is an environmental organism, which can be found in some patients, especially those with chronic chest disease. Contaminated water can also transmit the organism via:
  - Direct contact with the water for example through bathing/showering
  - Inhalation of aerosols
  - Medical equipment and devices rinsed with the contaminated water
  - Indirect contact from contaminated surfaces via health care workers hands
- The infection prevention and control team were working closely with the estates department in partnership with the contracted external expert advisor in monitoring and managing the situation. The report stated that expert advice was being sought from Public Health England to find a solution relating to the ongoing problem of positive results from outlets from the CCC.

Environment and equipment

- The CCC complied with the Health Building Note 02-04 guidance for critical care of patients who are classified as needing advanced or level 2 or 3 dependency care.
- Equipment had portable appliance testing (PAT) stickers with appropriate dates. A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use.
- Staff said bariatric equipment was not easily accessible but was able to hire quickly when required.
- We saw a system in place to repair equipment. One of the doctors from CCC was a member of the medical devices group to review equipment. There was a rolling programme for all equipment and we saw that all the equipment within the CCC was either new or up to two years old.
- Each bed space in the CCC had medical gas supply, vacuum and electrical sockets and ceiling mounted hoists. High backed chairs with foot elevation and tilting facility were available at all of the bed spaces.
- We observed a paediatric bed space set up ready for admission. This included a paediatric equipment trolley with a sealed kit for different aged and weights of children. Also available was a paediatric guidelines and reference folder.
- The CCC had appropriate equipment for use in an emergency. There were resuscitation drugs and equipment including a defibrillator and a difficult airway intubation trolley. We saw daily resuscitation equipment checks in place. We observed the resuscitation trolley had anti-tamper tags attached.
- All equipment trolleys had stock levels and shelf drawer locations listed for easy access.
- The CCC had designed and built an attachable portable unit for the end of a patient's bed. The unit was used when patients needed to go for a computerised tomography (CT) scan or a magnetic resonance imaging (MRI). A CT scan X-rays the body from different angles to build up detailed images of the inside of the body. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
- The main theatre complex was located close to CCC for accessing emergency support. There was a good level of

mobile equipment available including haemofiltration machines, cardiac output monitors, defibrillator, non-invasive respiratory equipment and portable ventilators.
- There was a range of disposable equipment available in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times.

Medicines

- Staff reconciled medicines weekly. We saw completed monthly audits in relation to checking stock and utilisation.
- Pharmacy staff allocated to the unit checked medicine charts daily through weekdays, and provided advice on, for example, doses and contraindications.
- Medicines and intravenous fluids were stored appropriately. Medicines were stored in locked cupboards.
- The CCC kept correct temperature for all medicines requiring refrigeration. We checked the refrigeration temperature checklists in the CCC and found no issues or concerns.
- Some prescription medicines under the Misuse of Drugs legislation are controlled drugs (CDs).
- The CD register clearly recorded the booking in of stock, the administration to a patient and any destruction of medicines. Stocks were accurate against the records in all those we checked at random in the CCC, the register had clear signatures and dates with no issues identified.
- At the changeover of the shift, the nurse in charge of the previous shift and the oncoming nurse in charge checked the CDs together. These procedures highlighted any discrepancies. We saw this consistently happening between each shift.
- The CCC handled all high-risk medicines such as potassium safely. Potassium ampoules were stored and recorded as a CD, which meant that there were two nurses checking the prescription and administration of the potassium. This helped reduce the risk of any medicine errors.
- We checked the patient's prescription charts. These included high-risk medicine prompts, venous thromboembolism (VTE) assessments, intravenous fluids and blood products. The seven charts had the appropriate dates and signatures. Patient's records identified all allergies such as penicillin. Non-administered medicines had the appropriate documentation.
- The CCC had access to microbiologists, who attended ward rounds. This ensured appropriate use of antibiotics to treat infections.
- Staff reported medicine errors using the trust's incident reporting system. We saw a folder within the staff room with learning from incidents outlined. Examples included a review of medicines at handovers. We observed this practice in place during a staffing handover.

Records

- In the CCC, patient records were current, clearly set out and provided a clear record of patients' care and treatment. We examined seven patients' care records. They included a summary of events requiring admission to the CCC and a consultant review on admission to CCC. However, the records did not record the time the patient was admitted to the unit or if the admission was within four hours of the decision to admit.
- The CCC used both paper and electronic information records. This included the identification of potential deterioration and automated scores such as calculations and fluid balances. We observed the medical team during medical handovers effectively updating the electronic system.
- We were informed that all patient records on CCC were electronic. However, in some cases paper records were also used. This meant that staff had to be aware of information being available in two records i.e. both paper and electronically. Staff said they were aware of this and would refer to both records for any information required.
- The records read had a Treatment Escalation Plan (TEP) in place. The aim of the TEP was to discuss potential treatment options and success, with those who were at risk of a sudden worsening of their health. The doctor or nurse created the TEP in consultation with the patient at risk and their relative and/or representative. This meant that nurses who were new on the unit had access to information on how to care for a patient.
- Nursing records included risks to the patient of developing:
  - Pressure ulcers
  - Malnutrition

  - Venous thromboembolism (blood clots)
- Incorporated into the patient's care plans were any actions needed to reduce identified risks.
- The documentation was contemporaneous, maintained logically and filed appropriately. Entries were signed, legible, clear and dated and there was evidence of daily consultant ward round documentation.
- The patient's healthcare records were stored securely in paper-based files in drawers by the nursing station, which helped with maintaining confidentiality.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet.
- All staff completed awareness training in safeguarding vulnerable adults and children as part of their mandatory training. The records showed that all critical care staff had completed their adult and children safeguarding training.
- Staff demonstrated an understanding of safeguarding both adults and children and understood the process to complete should there was a concern that an act of abuse may have occurred or that a patient was at risk of abuse.
- Staff said they discussed all patients and any issues identified referred to the safeguarding team at team meetings.

Mandatory training

- The CCC team mandatory training rate as of November 2015 was 99%. This was better than the trust target of 90%. Topics that were covered by the mandatory training for all staff included:
  - fire safety
  - information governance
  - equality and diversity
  - conflict resolution
  - health and safety
  - moving and handling.
- Clinical staff also had to undertake other mandatory training including; paediatric immediate life support (PILS) and use of medical gases. The records showed that staff were 100% complaint with these training.
- All staff had immediate life support training (ILS) with more senior staff having advanced life support (ALS) training. The CCC had a plan to put four staff a year through their ALS training.
- Staff had received advanced paediatric life support (APLS) training which was identified on the training records.
- There was twice yearly in-house transfer training which was classroom based and involved practical training on the transfer trolley.
- We observed that the records seen as of 4 December 2015 showed only 35% of staff had returned the medical devices training log. However, the records provided by the trust showed that 79% of staff had completed their training.

Assessing and responding to patient risk

- Staff monitored patients on CCC as outlined in the observation charts. This meant they could respond to any deterioration efficiently and quickly.
- Consultants reviewed all patients admitted to CCC within 12 hours of admission. The records reviewed confirmed this as well as the Guidelines for the Provision of Intensive Care Services (GPICS) report for 2015.
- Patients were nursed by recommended levels of nursing staff for example; level three (intensive care) patients were nursed by one nurse and level two (high dependency care) by one nurse for two patients. We observed an additional clinical support worker (CSW) had been allocated to a confused level two patient. This meant that the service had assessed and responded to the patient's individual needs.
- We observed good clear communication from the on-call consultant to the nurse in charge regarding an admission. There was a clear escalation plan and guidance of treatment communicated. This meant the nurse in charge had all the relevant information to provide care and treatment to the patient.
- There was a low admission rate to critical care of some high-risk patients for example; emergency laparotomy. The National Emergency Laparotomy Audit (NELA) states that all patients with the highest risk (over a 10% risk of death) should be admitted to critical care and all high-risk patients (5 and 10% risk of death) should be considered for critical care. We saw the trust guidance identified patients with the highest risk of death over 10% "should be admitted" to a critical care location. The guidance for high-risk patients between 5 and 10% at risk of death remained in recovery, seen by the outreach

team who assessed the patient's wellbeing, prior to either referral to the ward or admission to CCC. Doctors spoken with confirmed this procedure. This meant that the CCC assessed the risk to patients prior to admission.

- A critical care outreach (CCO) team supported all aspects of the adult critically ill patient, including early identification of patient deterioration within other areas of the hospital. The NEWS supported this process and was part of the patient observation chart. This meant there was an appropriate route which could be followed by staff should any patient trigger a high-risk score. The seven electronic records reviewed showed completed NEWS charts in accordance with trust procedures.
- Patients at risk of developing VTE such as, deep vein thrombosis from spending long periods immobile were assessed on admission to CCC. There was a daily review of patients for risks of developing VTE. Patients identified as at risk in line with NICE 83 (Statement 5) had compression stockings and sequential compressions devices provided.
- The CCO and the patient's medical team were able to refer the patient directly to the CCC for support, advice and review. The CCO provided 24-hour cover for the hospital as recommended in the Guidelines for the Provision of Intensive Care Services 2015. This service was consultant led five days a week. The nurse in charge oversaw the running of the service during the weekend.
- Patient flow through the CCC did not pose a risk to patient safety. The Intensive Care Society Core Standards for Intensive Care 2013 states that discharges should occur between 7am and 9.59pm. The records showed that discharges out of hours had occurred twice during April and August 2015 and we saw the created incident reports reflecting this.
- We saw completed care bundles for patients within the CCC. These included for example; central line insertion bundle, sepsis and tracheotomy care. Any identified risk had the required action to reduce or manage the area concerned for example; changing of dressings.
- Patients were safely ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using masks or similar devices. Staff completed checks on all ventilated patients who recorded their findings hourly. We saw this recorded on the records reviewed.

Nursing staffing

- The trust's electronic system managed and generated the nursing staff rotas.
- Staff nursing levels within CCC were meeting the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Staffing levels were in line with core standards at all times during our inspection. This included; level three patients (intensive care) nursed on a one to one basis whereas level two patients (high dependence) had one nurse for two patients.
- We saw the risk register for October 2015 identified shortness of staff as a risk. There were 11 staff (band 5 and band 6) vacancies within the unit which equated to a third of staff required. We saw the action plan. This included the implementation of a recruitment plan to reduce current vacancy rate and the use of bank staff.
- The CCC did not use agency staff, but utilised bank staff. There was an enhanced bank rate for critical care staff. The rotas showed that bank specialist nurses covered weekends. Senior staff said this supported specialist bank nurses to maintain their skills within critical care.
- The matron of the unit had recently retired and one of the consultants and two practice development nurses were overseeing the role. The nurse in charge of the unit was always supernumerary (did not have a patient allocated to care for) leaving them free to co-ordinate the shift. Staff rotas reflected this.
- The 24-hour CCO service worked closely with the CCC. The CCO was consultant led and attended the unit Monday to Friday from 9am to 1pm. The nurse in charge oversaw the running of the out of hour's service.
- There was good handover among nurses and we observed staff discussing the following:
  - Brief medical history
  - Reason for admission
  - Progress since admission
  - Physiological function
  - Action plans
  - Medicine charts
- Senior nurses covered night shifts. Staff told us that there was an arrangement whereby the senior nurse going off duty were automatically 'on–call' for any issues that may arise overnight. The senior nurses said they

had not had any occasion when they had to come in and were able to provide advice over the phone. We discussed this with the senior nurses who maintained that specialised advice particularly regarding CCC equipment might be required overnight.
- Senior staff said that critical care staff supported staff shortages weekly on other wards. The trust's policy ensured that staff returned to the CCC at less than one hour's notice.
- The CCC had a dedicated clinical nurse educator responsible for co-ordinating the education, training and personal development of critical care staff.

Medical staffing

- Eight consultant anaesthetists/intensivists with critical care experience maintained the CCC. There was a resident doctor under the supervision of a consultant at all times.
- Medical staff described a flexible teamwork approach to ensure that the CCC had support throughout the night with access to the on-call consultant. There were no reports of medical assistance being unavailable when required.
- Senior staff spoken with said there were no issues or concerns with vacancies within the service. The records showed that vacancy rates were at 7%. This was higher than the trust target of 5% but the information showed a steady decline from May 2015.
- The level of cover provided by medical staffing on the CCC was in line with professional standards and recommendations. The standards state that a consultant in intensive care medicine must undertake twice-daily ward rounds. The records we reviewed showed the unit was compliant with this.
- We attended a medical handover. The handover reviewed patient care based on the severity of their condition and any anticipated problems. The CCC night team handover to the day team took place prior to the ward round commencing.
- The CCC did not employ external locums. This meant the CCC was able to provide continuity of care for patients who used the service.
- Junior doctors confirmed that the induction programme they received was adequate. A consultant representing the Faculty of Intensive Care Medicine met the individual training requirements of trainees.
- Trainee rotas were compliant with recommendation from NHS Employers for trainees and European Working Time Regulations.

Major incident awareness and training

- Evacuation routes within the unit were free of clutter and kept clear. However, the fire exit on CCC was in a side room. The side room had a bed, table and pendants in situ. The severity of the patient's condition could mean the patient required a large amount of equipment at times. This meant that obstruction of the fire exit was inevitable. The health and safety team and fire officer had reviewed the site. The CCC had reduced the risk by assessing all patients prior to allocating the appropriate bed space. The divisional medical director and CCC had reviewed the control currently in place on 21 October 2015. The risk register identified that the mitigation plan was awaiting agreement from Bedfordshire fire officer.
- Staff had attended mandatory fire training and had knowledge of procedures in the event of a fire. The records showed that 99% had completed their training.
- There was a continuity plan with details of actions to take in the event of failure of power, loss of water or medical gas supply on CCC. We saw the emergency generator with bi-monthly checklists in place.

Are critical care services effective?

Good

We rated critical care as good for effectiveness.

The treatment and care provided followed current evidence-based guidelines. The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC). Policies and procedures were accessible for staff on the trust's intranet system. The CCC participated in national and local audits in order to measure their effectiveness. Data from audits showed there were good outcomes for patients treated in the critical care services.

The CCC managed patient's pain as well as the nutrition and hydration. Multidisciplinary working was evident to coordinate patient care.

Medical and nursing staff had the necessary skills that were consistent with core standards for critical care services.

Critical care

Staff had completed their induction and had received annual appraisal.

The critical care service had a consultant-led, seven-day service.

Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- The CCC used a combination of National Institute for Health and Care Excellence (NICE) and Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided. This included the guidance for rehabilitation. Patients had a rehabilitation assessment completed within 24 hours of admission to critical care.
- Policies were accessible for staff and were in line with national guidelines such as the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) guidelines for managing patients with a subarachnoid haemorrhage and managing patients with a tracheostomy.
- We saw the 2015 submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The ICNARC data supports critically ill patients by providing information about the quality of care provided.
- The service conformed to the Acute illness in adults in hospital: recognising and responding to deterioration (NICE Guidance 50). We saw staff following best-practice guidelines which included for example; the National Early Warning Score (NEWS) with a graded response strategy to patients' deterioration.
- The CCC used the acute respiratory distress syndrome (ARDS) protocol. ARDS is a severe form of acute multifactorial lung injury with acute hypoxic respiratory failure. Senior management told us they were reviewing this procedure in line with the trust's ventilation guidelines policy.
- The CCC was working towards NICE guidance 83: Rehabilitation after a critical care in adults. The guidance recommended there should be a follow-up clinic for patients to determine if they needed further input after two to three months after discharge home. Senior management confirmed they were in the process of creating a management plan to address this issue, as currently they did not have a follow up clinic for critical care patients.
- The CCC conformed to the NICE guidelines 135 for organ donation for transplantation. This clinical guideline offers evidence-based advice on identifying potential organ donors resulting from a brainstem death or circulatory death.
- The CCC was able to accommodate children and had guidelines and protocols for any child pending retrieval from the Children's Acute Transport Service (CATS). CATS provide an intensive care transport team for paediatric services. Senior staff said they had access to paediatric nurses and doctors within the CCC.
- The unit had completed a self-review of their achievement under the Guide for Provision of Intensive Care Services (GPICS standard, 2015). Areas covered included; patient pathway, resilience planning, improving the service and disease management.
- The CCC followed NHS guidance when monitoring sedated patients, by using the Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the assessment of the patient for different responses, such as alertness (scored as zero) and then behaviours either side of that from levels of agitation (positive scoring) to levels of sedation (negative scoring). Any scores below the baseline of zero (or below the score desired by the prescribing doctor) would indicate the need for a discontinuation of the sedation infusion (termed a 'sedation hold') to monitor the patient's response. Obtaining a RASS score is the first step in administering the Confusion Assessment Method (CAM), a tool to detect delirium in intensive care unit patients.
- The CCC met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. The CCC led on organ-donation work for the trust. There was a specialist nurse for organ donation based at the hospital, to directly support the organ donation programme and work alongside the clinical lead.
- The matron for the CCC had recently retired and the consultant lead and two senior nurses (band 7) were overseeing the role. They told us they were currently reviewing all policies and guidelines. Examples included; sedation policy and the standard operating procedures for the unit. We saw updated copies in folders within the staff room and the trust's intranet.

Pain relief

- The CCC said they planned and delivered pain relief in line with the Core Standards for Pain Management

Services in the UK (CSPMS). We saw a copy on display within the staff room. We observed during ward rounds and medical handovers, staff discussed the pain-relieving needs of each patient and their pain management plans. We saw each patient's record adjusted accordingly on the trust's electronic system.
- We observed staff monitoring patients' pain and response to pain relief as part of their routine observations.
- A nurse specialist in pain control was contactable by telephone for advice, and would see a patient if asked.

Nutrition and hydration

- The unit used the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of malnutrition. The tool evaluated the risk by taking the patient's body mass index (BMI) and any recent weight loss, acute illness, mobility, age and sex.
- Patients that were able to drink had access to drinks by their bedside. Care support staff and completed fluids balance charts monitored the intake of regular drinks.
- We observed a patient eating breakfast on a tray while they sat out of bed on a chair. The nursing staff offered assistance and ensured that the patient was able to eat independently. Staff completed food charts to monitor patient's food intake.
- Staff said they would make a referral to a dietician as required. We saw written weekend plans for patients. We saw regimes in place for patients who received nutrition via a feeding tube. This meant that staff had the necessary guidance to support the patient's nutrition or hydration needs.
- The records showed that nursing staff had achieved critical care competency in the administration of intravenous drugs and fluids. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital.

Patient outcomes

- During 2014/15, 52 national clinical audits covered relevant health services that Bedford Hospital provided. The trust had completed 41 of the 52 (79%). Examples of critical care services participation included:
  - Intensive Care National Audit and Research Centre (ICNARC) audit
  - National Emergency Laparotomy Audit (NELA)
- The ICNARC quality report for April to June 2015 (published September 2015) found the trust was significantly worse than the England average trust performance for the two measures related to delayed discharges i.e. 12-hour delay and 24-hour delay. Trust performance was within the expected range for all other measures for example; MRSA, non-clinical transfers and mortality. The critical care risk register identified delayed discharge as an area of concern. Actions included daily attendance at operational meetings and informing patients and relatives of any delays.
- The nurse in charge undertook daily quality rounds that looked at patient safety. Examples included; drug charts, care plans and observation charts such as NEWS and fluid balances. The information was available in a folder within the unit. Senior staff said this information was included in the unit's audit and provided the opportunity to share future learning with staff.
- The unit collected the data in respect of how much rehabilitation time patients received. The patient, for a minimum of five days a week should receive a minimum of 45 minutes of active therapy per day. This should be at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it. We saw the data collected for September and October 2015. Forty-six patients (73%) had received active therapy whilst 17 (27%) did not receive any therapy. The records showed that only one of the 63 patients had received 45 minutes of rehabilitation per day. However, the records showed that the remaining patients (45) had received between 15 and 45 minutes per day. Areas for non-receipt of rehabilitation included; the patient being drowsy, declined by the patient and the patient unstable due to cardiovascular issues.
- We saw the results of the Eastern donor after cardiac death (DCD) audit from April 2014 to May 2015. DCD refers to a patient receiving assisted ventilation with a clinical decision to withdraw treatment. Bedford Hospital had two (7%) actual donors.

Competent staff

- Staffs had their competency, skills and development assessed each year. The appraisal rate for CCC was 100% at the time of inspection for nursing staff.

- Information regarding medical staff appraisal and revalidation provided by the trust showed 100% compliance. The consultant lead for the CCC confirmed this; they had conducted all the relevant appraisals.
- Ward staff both qualified and unqualified had completed the Acute Life Threatening Events Recognition and Treatment (ALERT) training. ALERT is a multi-professional course to train staff in recognising patient deterioration and act appropriately in treating the acutely unwell.
- Staff on CCC had completed the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH). BEACH empowers staff with the skills and techniques required to recognise and escalate a deteriorating patient.
- We saw competency based induction programmes for nursing and clinical staff. We saw signed off records for three staff.
- There were strategies in place for band 7 nurses within the CCC. The strategy outlined their areas of responsibility such as the management of the unit and patients.
- Leadership and development using the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) programme was available for managers and senior nurses. The programme looks at four domains namely; safe and effective practice, enhancing the patient/client experience, leadership and management and delivery of organisational objectives. We saw action plans for staff undertaking the programme.
- Core standards state that 50% of critical care staff should hold a registration award. We saw that over 70% of staff had completed their National Competency Framework for Adult Critical Care Nurses (Steps 1 to 3).
- The outreach staff had attended a National Outreach Forum (NoRF) programme. NoRF provides a forum for CCO service providers and recipients to improve the quality of the patient's treatment, care and experience. Areas covered included; rapid response, patient safety and clinical governance and education, training and support. We saw four records that staff were currently completing.
- Every Wednesday lunchtime doctors invited the nursing staff from the CCC to join them in a teaching session. This was in addition to dedicated nurse teaching sessions.

Multidisciplinary working

- The CCC had input into patient care and treatment from the physiotherapists, pharmacists, dietitians, and speech and language therapists as per the Royal College of SLTs guidance, microbiologist (a healthcare scientist concerned with the detection, isolation and identification of microorganisms that cause infections) and other specialist consultants and doctors as required. All the professionals we spoke with described positive working with the CCC team.
- We observed good multidisciplinary team (MDT) working during a staff handover. The MDT were involved in discussions on patients.
- The unit had an outreach team that provided valuable support in the care of the critically ill patients. The CCO team reviewed any patient who would benefit from their intervention or whose condition was causing concern within other areas of the hospital. The team also followed up all patients discharged from the CCC. There was no limit to the reviews and these would be done as often or as little as required.
- There was clear evidence of involvement by the MDT within the patients' records.

Seven-day services

- Physiotherapists came to the unit every day. The senior physiotherapist received a handover from the CCC nurse in charge and then allocated physiotherapist from the team to see certain patients.
- Staff said they had a good working relation with the SLT and confirmed they were accessible as required.
- Pharmacy provided a service to CCC Monday to Friday and Saturday mornings. Outside of these hours, advice was available via the on call pharmacist.
- A dietitian service was available Monday to Friday for the CCC with an on-call service at weekends. There were protocols for nursing staff to commence enteral feeding on CCC patients out of hours.
- The CCO provided a 24-hour service seven days a week. This was consultant led Monday to Friday 9am to 1pm. Outside of these hours the CCO was overseen by the nurse in charge.
- The CCC had access to a general surgeon on-call and an emergency theatre team 24 hours seven days a week.

Access to information

Critical care

- The CCC used electronic handover sheets to ensure that all staff had up-to-date information about patients in their unit.
- The bank staff also had access to the information in care records to enable them to care for patients appropriately.
- All staff had trust e-mail accounts to access updates electronically.
- In the CCC, there was clear communication of patient information verbally on the ward round. Medical assessments that supported effective transmission of all relevant information on the round were in the form of a proforma. At the same time, the consultant personally documented the patient's plans of treatment to ensure that all information was accurate.
- Patients transferred to other wards in the hospital or outside competed discharge forms. Verbal handover also took place via telephone or face to face.
- The initial medical handover process for the CCC to the night team involved the completion on the electronic handover system followed by a ward round. This meant that all on-call medical staff had the relevant information which reduced the risk to patients.
- Staff had access to relevant information to assist them to provide effective care to patients during their CCC stay. Healthcare records at the trust were both paper and electronic based. The paper records were available at the patient's bedside. Some information, including results from patient tests and guidance was available via the trusts electronic system.

Consent and Mental Capacity Act

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with Mental Capacity Act 2005 (MCA) when treating an unconscious patient, or in an emergency. A review of consent forms in patient notes showed an appropriate member of the medical team had correctly completed them.
- Staff confirmed they had completed their MCA training and had completed the accompanying assessment workbook. The training records showed all staff had completed their training.
- We saw a question and answer booklet to support staff on how to complete a MCA assessment.

Are critical care services caring?

Good

We found critical care services to be caring.

Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives received good emotional support. Throughout our inspection, patients' received good care, compassion, dignity and respect.

Patients received and felt involved in the care and treatment provided. Relatives and visitors were happy with the level of emotional care and treatment they and their loved ones had received.

Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care, we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak with said staff were "fantastic" and one relative said they "could not fault them".
- We observed many caring and compassionate interactions between staff CCC and the patients in their care. One example observed was the gentle encouragement to use a wheelchair within the ward. The therapist took time to reassure and provide explanation and orientating information. Following this exchange, the patient appeared relaxed and determined to complete the activity.
- During the ward round, medical staff talked to patients (including those that were sedated), and explained what was happening to them.
- We observed good attention from all staff to patient privacy and dignity. Curtains were drawn around patients and doors closed when necessary. Staff lowered their voices when discussing confidential or private information. The nature of most critical care units means there is often limited opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity.
- The NHS Friends and Family Tests (FFT) were questions asking patients if they would recommend the ward to their family and friends. The hospital asked these

questions of patients when leaving the hospital. As very few of the patients were discharged from CCU (they usually went to a ward before ultimate discharge) they were not participating in the test.
- We saw completed Patient and Relative Experience Satisfaction Survey results for 2014. However, the response rate was low with only 10 responses returned. The results showed that relatives found the unit treated patients with respect and looked after their welfare.
- We saw many complimentary cards within the CCC. One card said, "thank you for all the care and attention" and for being "lovely, understanding and patient." Another card said, "Your collective care, love, empathy will always remain in our hearts."

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Those patients who were able were encouraged to talk about anything worrying them. We observed staff, both doctors and nurses talking inclusively with patients and their relatives.
- During bedside handover, staff included details of relatives including who was the main contact.
- During the ward round, we witnessed the medical staff having full discussions with a patient using appropriate language about the patient's prognosis and diagnosis.
- Patients that were conscious were fully involved in discussions during ward rounds and given the opportunity to ask questions.
- The unit used a password system to ensure that only those relatives/friends that were entitled to information received it. Telephones on the unit had reminders for staff to check for passwords.

Emotional support

- The CCC team demonstrated that they appreciated the emotional turmoil that patients and relatives experienced due to critical illness and CCC admission. They provided a supportive, kind and unrushed approach. We observed a nurse reassuring and providing explanation to a patient that was concerned because they could not remember what was happening.
- Many patients experienced stress following a stay in intensive care; this often was due to a lack of recall of their stay. The unit had introduced patient dairies. Staff said that patients and relatives feedback regarding the diaries was positive. Benefits included a better understanding of the events of critical illness helping them with more realistic goal setting during their recovery period, improving communication within families through discussion of the diary and providing a source of comfort for the bereaved.
- The chaplaincy offered support as required and provided a booklet in the relative's waiting room. Staff said the local Imam visited patients to provide prayers as required.
- There was a specialist nurse for organ donation based at the hospital. They directly supported the organ donation programme and worked alongside the clinical team.
- The CCC worked alongside the Intensive Care Support Teams for Ex-patients (ICU Steps). Patients, their relatives and CCC staff could the service. The ICU Steps team provided support to patients on their recovery from critical illness.

Are critical care services responsive?

Requires improvement

We rated responsive as requires improvement.

The ICNARC data from March to June 2015 showed that the CCC had more delayed discharges (more than four hours) than similar intensive care units. Senior staff confirmed that transfer out of the unit posed problems every day due to the lack of capacity of ward beds. The records from April to August 2015 showed there had been a total of 58 delayed discharges of more than 24 hours and three delayed discharges of more than four hours but less than 24 hours. Due to the delayed discharges, this meant that the CCC had difficulty in ensuring patient's privacy and dignity due to mixed-sex breaches. The CCC did not complete an incident report for any mixed-sex breaches and staff confirmed they were unaware how may or how often these occurred.

The CCC did not have psychological support for patients, relatives or staff. This had been identified as a recommendation by the Guidelines for the Provision of Intensive Care Services (GPICS) report for 2015.

The location of the CCC near the operating theatres enabled staff to respond efficiently and effectively to

emergencies. Despite issues with flow transferring patients out of the CCC, they were responsive to emergency admissions. Planning of delivery of the service was coordinated at daily bed management meetings.

The critical care outreach team (CCO) provided follow-up support to discharged patients. The CCO team were involved in discharge planning and visited patients on the wards after discharge from the CCC to offer continued support.

Patients discharged from CCC did not have access to follow-up clinics. This contravened NICE guidance 83. However, senior staff described the business plan they wished to implement regarding follow-up clinics.

The records did not identify patient documentation regarding the time and decision to admit to CCC. Staff confirmed they did not record the data. Following the inspection, the trust began monitoring decision and admission times.

Staff understood the procedures regarding complaints.

The CCC was responsive to people's individual needs. Friends and families said the service was helpful by having flexible visiting times and they were very supportive during their bereavement.

Patients' relatives said they were involved and kept informed as much as possible. There was good awareness of the needs of people living with dementia, learning disability or mental health needs. They had access to the allied mental health professional (AMHP) and liaised closely with them.

Communication tools such as picture books were available to assist patients. Staff told us that they could access interpreters for patients that speak a different language.

Service planning and delivery to meet the needs of local people

- Patient's needs had been met in the design and planning of the service. The unit was located near the operating theatres to enable staff to respond to emergencies. Despite issues with flow transferring patients out of the CCC due to bed pressures in the hospital, they were responsive to emergency admissions.
- The CCC met the recommendations of the Department of Health guidelines for modern critical care units as they related to meeting patient needs and those of their visitors. These included:
  - Bed spaces were capable of giving reasonable visual and auditory privacy
  - There was natural daylight available for most bed spaces
  - There were facilities for patients who were well enough to have a shower or use a toilet. The CCC had one shower and one toilet.
  - Entry to the CCC was intercom-controlled and exit was via a coded system which was accessible only to staff.
- There was an organ donation service attached to the unit. We saw the audit for April 2014 to May 2015. The specialist nurse-organ donation (SNOD) received 44 referrals (98%) for consideration for donation of which three proceeded to organ donation.
- The CCO team was involved in discharge planning and visited patients on the wards after discharge from the CCC to offer continued support. The critical care follow up figures showed the CCO had achieved 100%.
- Planning of delivery of the service was coordinated at daily bed management meetings.

Meeting people's individual needs

- The trust did not have psychological support for patients, relatives or staff as recommended by the Guidelines for the Provision of Intensive Care Services (GPICS) report for 2015. Consultants confirmed they were actively reviewing the need for psychological support.
- The unit had a remembrance box. Staff had the ability to take for example; prints of a relative's hand. Staff said that friends and families had told them they found this service helpful during their bereavement.
- Staff had good awareness of the needs of people living with dementia, learning disability or mental health needs. They had good access to the allied mental health professional (AMHP) and liaised with them regarding any assessments required.
- Communication tools such as picture books were available to assist patients who were unable to communicate for example, due to airway tubes being in place.

- Staff told us that they could access interpreters for patients that spoke different languages and signposted us to information on the trusts intranet.
- There was a range of booklets, leaflets and information for both patients and families. For example, leaflets and booklets about the unit, pastoral and spiritual care. These were in English but the trust had the facility of arranging the literature in a different language upon request.
- Visiting times could be flexible to meet the needs of the patient and their relatives/representatives.
- There was provision of facilities for visitors to the CCC. Visitors had access to a waiting room, where hot, and cold drinks were available. This was located just outside the unit for visitors to wait or to enable visitors to step away from the unit if they wanted a break. There was ample seating and a private room where staff and family could have discussions. Relatives could stay overnight when required.
- Bedford Hospital, in conjunction with Access Bedford and Healthwatch Bedford Borough, launched a new and confidential direct email service for deaf people in March 2015. This meant that deaf people could email the hospital's switchboard direct, 24 hours a day, for enquiries rather than phoning.

Access and flow

- Access to transfer patients from the unit posed problems every day. The nationally agreed standards for critical care state that discharge from intensive care should occur within four hours of the decision that the patient no longer requires level 2 or 3 care, and there should not be a non-clinical reason preventing such a move.
- ICNARC dated from March to June 2015 showed that the CCC had more delayed discharges (more than four hours) than similar intensive care units. Data collected by the trust for CCC showed that this was a concern across the unit. Critical care consultants said they had patients daily who were delayed in the CCC, once ready for discharge, because there were no ward beds available to give them.
- The records from April to August 2015 showed there had been a total of 58 delayed discharges of more than 24 hours and three delayed discharges of more than four hours but less than 24 hours. The unit had a worse than expected number of delayed discharges in the ICNARC Report 2013/14, meaning more patients had delays of 12 and/or 24 hours than should be expected.
- The unit had clear and safe pathways for escalation of care from level 2 to level 3.
- Delays in discharging from level 2 beds meant that patients, who had improved to level 1, were treated in areas that were inappropriate for their needs. There was the risk that staff could not promote their privacy and dignity effectively due to mixed-sex breaches.
- To meet patient's privacy and dignity, level 1 patients were cared for in side rooms. However, this was dependant on availability of side rooms as their priority use was for isolating patients to reduce risk of spread of infections. We found four level 1 patients on CCC, during our inspection. We saw staff had completed the appropriate Delivering Same-Sex Accommodation (DSSA) form and sent this to the director of nursing within the hospital. The unit did not complete an incident report for sex breaches. Staff confirmed they were unaware of how many sex breaches had occurred within the unit and did not receive any feedback.
- The nationally agreed standards state that patients "should not be transferred" between wards between the hours of 9:59pm and 7am. This is for safety reasons and because patients find it unpleasant to be moved from critical care areas to a general ward outside of normal working hours. The prime reason for the delayed discharges was a lack of beds available on the general wards. The records showed there had been 11 late transfers between April and August 2015.
- Bed occupancy has averaged 86% since January 2014, in comparison to the England average of 80%. The records for April to August 2015 showed there had been no cancelled elective surgery due to the lack of a critical care bed.
- Patients remained in recovery for four to five hours and then may be assessed by the outreach team prior to returning to the ward. Doctors said they were reluctant to admit to CCC due to the difficult in obtaining a bed and maintaining patient flow. This meant that patient's risks were assessed prior to discharge from recovery.
- Patients discharged from CCC did not have access to follow-up clinics. This contravened NICE guidance 83. Senior staff described the business plan they wished to implement regarding follow-up clinics.

- The seven records read did not identify patient documentation regarding the time and decision to admit to CCC. Staff confirmed they did not record the data. This meant the unit did not know if they were meeting the four-hour target of the decision to admit. The ICNARC data for April to June 2015 showed that there had only been four patients (3%) in 141 admissions recorded. This was brought to the attention of the trust who responded and implemented the monitoring of decision and admission times to CCC.

Learning from complaints and concerns

- Reported complaints were in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.
- Staff understood the hospital's complaints policy and knew how to manage any complaints they received. They all said they would try to resolve any concerns or complaints that a patient might have before they escalated into formal complaints. Information about complaints processes were on display in the unit area.
- Patients and relatives said they would voice concerns or complaints directly to the nurse in charge of the shift or the nursing caring for them. They were confident that staff would promptly deal with any concerns and complaints.
- Staff said they had received feedback from patients about their food being cold. This resulted in staff researching and finding insulated boxes that could maintain the temperature of food. We saw this in use for a patient during our inspection. The unit had six boxes within the CCC.

Are critical care services well-led?

Good

We rated the service as good for well-led.

We saw clear guidelines around the safe running of the service. There was an operational policy and clear strategies to support staff and senior nurses with the management of the service. Regular critical care governance meetings discussed risks to the service. Senior staff and clinicians attended these meetings. Examples included education and human resource issues. There were identified actions and responsibilities.

The service had recently undergone a reconfiguration with the appointment of a new clinical director. Motivated, accessible and experienced consultants and senior staff oversaw the running of the CCC. CCC staff said that consultant and anaesthetists were supportive. Communication, morale and working together as a team had improved and they enjoyed coming to work. Staff within the CCC said the non-executive directors often visited the unit.

The staff survey results showed staff feeling satisfied with the quality of work and patient care they were able to deliver. Twice daily safety huddles meant that staff had all the relevant information to support patients within the unit.

There was poor feedback (10 responses) to the patient and relative experience satisfaction survey. However, relatives said they saw staff treating patients with respect and were happy with the service provided.

Although a clear vision and strategy for the future of the critical care service team was not evident, senior managements were aware of the shortfall. They said they wished to implement the trust wide strategy before reviewing the CCC's strategy. Some staff said they were unclear of the vision for the service.

We saw bi-monthly minutes of critical care mortality and morbidity meetings. We observed there was no systematic review of all mortality and morbidity on critical care. There were no actions identified with no time scales attached

Vision and strategy for this service

- A clear vision for the future of the critical care service team was not evident. Staff spoken with confirmed this. Staff said that the trust's vision and values ensured they put "patients first." They felt this was part of the culture of the trust.
- Senior management said there was not a strategy for critical care. However, they confirmed this was due to the engagement of new management and wished to implement the trust wide strategy before looking at a strategy for critical care. They said this would ensure stability within the team and improve staff morale.
- Senior staff's aim was to rebuilding the team whilst keeping the patients within CCC safe.

Governance, risk management and quality measurement

Critical care

- There was an operational policy in place for the CCC with clear guidelines around the safe running of the service.
- Senior staff and clinicians attended critical care governance meetings. Discussed at governance meetings were risks to the service and significant events in other areas of the hospital such as mixed sex breaches and delayed discharges. These included; HR issues and education. There were identified actions and who would be responsible for them.
- The service had meetings whereby information from the hospital clinical governance team was cascaded to staff. This included information on incidents and audits. Newsletters, emails, discussions at handovers and one-to-one meetings were evident for staff who could not attend staff meetings. Staff confirmed they received information about issues relating to the unit, division and the trust as a whole.
- Senior staff on the CCC conducted monthly workforce meetings to review staff's health and wellbeing. This included recruitment and retention interviews.
- We saw the bi-monthly minutes of critical care mortality and morbidity meetings. Examples of areas covered were; medicine management, ICNARC data and case studies. We observed there was no systematic review of all mortality and morbidity on critical care. There were no actions identified with no time scales attached. For example, the minutes for September 2015 identified the need for an audit of all outreach referrals and results. We found there was no reference to this in the following meeting minutes.
- The critical care register identified areas of concern which was reviewed monthly. We saw there were actions and controls in place.

Leadership of service

- The service had recently undergone a reconfiguration with the appointment of a new clinical director. Staff confirmed that morale within the staff team had improved since the appointment.
- Motivated, accessible and experienced consultants and team managers oversaw the running of the CCC. Throughout the inspection, they responded appropriately to incidents and areas that required immediate action.
- CCC staff said that consultant and anaesthetists were supportive. Communication, morale and working together as a team had improved.
- Staff within the CCC said the non-executive directors often visited the unit. They said this had improved staff morale and provided a greater awareness of their role.

Culture within the service

- A member of the medical staff commented that the safety culture was very strong on CCC. From working on the unit, they had learnt lots about the importance of teamwork.
- Nurses appeared to have a good rapport as a team and were very patient focussed. A staff member said the unit is a great place to work and they loved coming to work each day.
- The service had a healthy incident reporting culture. There was a high reporting rate of no or low harm events. It was clear any member of the team was encouraged to share concerns and report incidents. Feedback on the staff notice board indicated staff received notification of any incidents.

Public engagement

- There was poor feedback (10 responses) to the patient and relative experience satisfaction survey for 2014/15. However, relatives said they saw staff treating patients with respect and were happy with the service provided.
- Senior staff said they were aware of the shortfall in obtaining feedback and were reviewing how they could capture patient responses.
- During our inspection, we saw a number of cards and letters from patients and their relatives thanking staff for the care they had received in CCC.

Staff engagement

- Staff told us that staff meetings and handover sessions kept them informed and involved in the running of the critical care service at the hospital.
- Bedford Hospital was in the top 20 acute trusts in the country for staff engagement and the top 20% for motivation, according to the 2014 NHS staff survey results published in March 2015. The results showed staff feeling satisfied with the quality of work and patient care they were able to deliver and recommended Bedford Hospital as a place to work or receive treatment. Two areas that fell below the national average included; staff feeling that their trust did not

value their work and communication between senior managers and staff was not effective. Staff within the CCC confirmed they agreed with the findings of the staff survey.

- There were fortnightly staff meetings as well as twice-daily safety huddles within the unit. This meant that staff had all the relevant information to support the care and welfare of patients within the unit.

Innovation, improvement and sustainability

- The CCC participated in the "Breathe" trial. The completion date for this trial was January 2016. This trial was in conjunction with the Intensive Care Foundation. Patients with respiratory failure who had received invasive ventilation for more than 48 hours (from the time of intubation) and who had failed a spontaneous breathing test (SBT) were randomly selected as an intermediate step in the weaning of patients off invasive ventilation. Senior staff said they would analyse the results of the trial once received and disseminate to the staff team.
- The CCC had designed and built a portable unit, which could be attached to the end of the patients' bed when they needed to go for example; an x-ray.

Maternity and gynaecology

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

Information about the service

Bedford Hospital NHS Trust provides maternity and gynaecology services at Bedford Hospital.

The maternity service at Bedford Hospital NHS Trust is part of the women and children's directorate which also provides gynaecology, genito-urinary medicine, neonatal and paediatric services. Bedford Hospital NHS Trust provides integrated hospital and community maternity services.

A total of 2,859 deliveries were reported by the trust during 2014. Of those, 2,813 (98.4%) were single births and the remaining 46 (1.6%) were multiple births.

The trust has 24 maternity beds and 24 cots on the Orchard maternity ward. There are four day assessment unit (DAU) beds. The delivery suite has 10 beds including the Acorn low risk rooms and the bereavement suite. There are 10 inpatient beds in orchard gynaecology ward.

The maternity service at Bedford Hospital offers: a consultant-led delivery suite, the acorn midwifery led suite, a dedicated bereavement room, an outpatient antenatal and gynaecology clinic; a day assessment unit (DAU); a triage unit; and antenatal and postnatal inpatient wards. Women can also choose to have a home birth supported by community midwives. Two teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The maternity services also include specialist provision, for example for women with diabetes.

The gynaecology services at Bedford Hospital offer inpatient care, outpatient care and emergency assessment facilities, including an early pregnancy assessment unit (EPAU). Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment. A team of gynaecologists receive support from specialist gynaecology nurses, general nurses and healthcare assistants.

We visited all wards and departments relevant to the services. For maternity services we spoke with ten patients, two relatives, 12 midwives and support workers individually, and 11 midwives in a focus group. For gynaecology services we spoke with three patients, two relatives and three nurses. We also spoke with four medical staff who worked across both maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as requiring improvement. We found the service requiring improvement for being safe, responsive and well-led, and good for being effective and caring.

We found that the clinical governance system was not robust. Senior staff within the maternity unit did not manage incidents in a timely manner and in accordance with best practice. We reviewed the trusts serious incident policy and maternity risk policies and found that the staff in the maternity unit were overall following the trust policy but there were gaps and weaknesses in the policy. 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 incident investigation reports to included learning and conflict of interest.

In response to a cluster of serious incidents in maternity, the trust was reviewing all intrapartum deaths and stillbirths in the past year and had commissioned an external review of the maternity service.

Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Patients told us they had a named midwife. The ratio of clinical midwives to births was one midwife to 30 women which was worse than the national target of one to twenty eight women. The trust provided evidence of one-to-one care during labour which is recommended by the Department of Health. Women told us they felt well informed and were able to ask staff if they were not sure about something.

Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology wards.

Are maternity and gynaecology services safe?

Requires improvement

Overall we rated the service as requiring improvement for safe.

There was an increased risk to patient safety because there was limited assurance about safety measures. Systems, processes and standard operating procedures in maternity were not always reliable or appropriate to keep people safe.

Although the trust board was always aware of the status of incidents in maternity we saw evidence that demonstrated that the trust was not consistent in its review and analysis of incidents. Senior staff did not assure us that investigations were monitored and action plans reviewed and closed. We reviewed the trust serious incident policy and maternity risk policies and found that the staff in the maternity unit were overall following the trust policy but there were gaps and weaknesses in the policy. 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 incident investigation reports to included learning and conflict of interest.

Nine serious incidents were reported for maternity and gynaecology to the Strategic Executive Information System (STEIS) between April and December 2015. Between October and November 2015 the hospital declared a cluster of five serious incidents relating to maternity services. Previously, the trust had declared eight over an 18 month period.

At the time of our inspection we could not accurately identify how many intrauterine deaths and stillbirths had taken place in maternity. After the inspection, the trust provided us with information that demonstrated there were six reported stillbirths in 2014/15 and seven between April and December 2015.

Maternity and gynaecology

The named midwife was model was in place and women told us they had a named midwife. We saw evidence that women 96% of women said they received one-to-one care in labour in August 2015 rising to 100% in September 2015.

All areas of the maternity and gynaecology service we visited were visibly clean and well maintained with display boards detailing cleanliness and safety information. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that the equipment was safe for use.

The planned and actual staffing levels were displayed on all wards in the gynaecology and maternity units and were mostly in accordance with national requirements.

Incidents

- Staff told us that they were able to raise concerns and were confident that their concerns were listened to.
- There was a strong reporting culture in the unit. We saw that 990 maternity and 40 gynaecology incidents were reported between September 2014 and August 2015.
- Escalation of incidents was identified through a computer based incident reporting system, Datix™. Incidents were flagged via Datix to clinicians and the executive team. This allowed them to question the clinical teams and review the incident to gather all information. The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. We were told that all incidents were reported according to the Serious Incident Framework (NHS, March 2015). The incidents would be initially reviewed by the maternity risk manager and discussed with the trust senior management team, we were told that whether an incident met the criteira for a serious incident (SI) was decided on a case by case basis by the executive team and that following every reported SI, a full investigation was undertaken and a report developed in line with National Patient Safety Agency (NPSA) good practice. Lessons learned were fed back to staff in 'Quality Improvement' a monthly clinical risk newsletter, the monthly maternity risk management report and at ward and departmental meetings.
- We found inconsistent allocation of the level of harm in line with NPSA and the National Reporting and Learning System (NRLS) definitions of harm. We saw that there was a variation in the assessment of harm. For example, September to December 2015 contained nine incidents relating to third or fourth degree tears. Four of these were classified as causing moderate harm, four were classified as causing low harm and one was classified as causing no harm. We found the same discrepancy for fetal death. The log of maternity incidents for September to December 2015 contained four such incidents. Two were classified as causing severe harm; one classified as causing moderate harm; and one was classified as causing no harm. We raised this with management who were unaware of these discrepancies.
- 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.
- We reviewed 17 SIs that had taken place across the directorate since April 2014, 14 of which related to maternity and three to gynaecology. A summary of each SI was provided to us along with actions taken following the investigation and the root cause/learning themes. Following analysis of all cases the key areas of focus were training and supervision, clinical management, patient and staff experience and governance.
- We also reviewed the governance policy and found that the policy was weak in some areas which resulted in less confidence in the SI process than would be expected. We found that the SI reports were not of a consistent standard. However, the trust did provide RCA training workshops for SI lead investigators, that included guidance on undertaking interviews and obtaining witness statements. The trust policy on the management of SIs outlined when, who and how to undertake level 3 investigations. Furthermore, the trust had developed an RCA toolkit, which included the RCA training presentation slides, to support staff.
- There was also a maternity policy that did not reflect the trust wide policy. The executive team told us that they were unaware of the additional maternity policy in place, indicating that the policy had not followed the trusts governance processes for policy implementation.

Maternity and gynaecology

- At the time of our inspection we could not accurately identify how many intrauterine deaths and stillbirths had taken place in maternity. After the inspection, the trust provided us with information that demonstrated there were six reported stillbirths in 2014/15 and seven between April and December 2015. Following our inspection the trust commissioned a retrospective review of still births.
- We were not assured that the trust approach to incident management was timely and enabled quick mitigation of the risks relating to the health, safety and welfare of service users. We had concerns around the timeliness of executive involvement in scrutinising reports. According to the policy the executive team did not review the SI report until 45 and 60 days post incident.
- We reviewed some RCAs and found that action plans were not always searching or questioning enough. Some of the actions in the action plans were overdue and a range of progress updates/ comments were not documented on the plan. It was unclear that adequate learning was drawn from the RCA and action plan.
- We looked at a SI related to a maternal death where we identified additional learning points that did not feature within the action plan. For example, the action plan did not demonstrate contributory factors, lessons learnt or changes in practice were not considered.
- The trust used a checklist from the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) report on full term stillbirths (November 2015) as a quality measurement tool for the intra-uterine deaths they had in December 2015.
- A SI executive group met three times a week. Membership of this group included the medical director, director of nursing and patient services, chief executive officer, deputy director of clinical governance and risk and patient safety manager. This group evaluated clinical incidents as SIs based on the NHS England SI Framework, the trust's SI screening form and clinical review of notes within divisions. There was no representation from obstetrics or midwifery on this group which meant there was a risk that evaluation of clinical incidents as SI's might be missed owing to clinical experts not being present. However, there was obstetrics and/or midwifery representation at the fortnightly SI review panel meetings chaired by an executive. This panel monitored the trust's SI log and action plan tracker and fed into to SI executive group.
- The trust policy stated there should be a thematic review of all SIs at least six monthly and this should be shared through the trusts governance structure. We saw a copy of the thematic review of SIs for April to September 2015 and noted that one maternity SI was thematic reviewed.
- The policy also stated learning was to be shared across the trust via forums and newsletters. The November 2015 newsletter was reviewed and we saw that four SIs were reported but no learning from them was described.
- However, we found that lessons learned were discussed and minuted in a variety of meetings. For example the audit meeting contained a 'lessons learned' agenda item, describing learning points such as the Situation, Background, Assessment and Recommendation (**SBAR**) tool must be used on handover between staff and this was to be audited to monitor compliance, as a previous audit identified use was poor.
- We asked staff about changes that had been made in response to lessons learned. We saw that, due to the communication breakdown identified in one SI report, a handover document was developed and was in use. A Second Stage Warning Tool was developed to monitor women in the second stage of labour. This was a traffic light system alerted the coordinator that a review of a woman in the second stage of labour was required.
- There had also been two inquests where the Coroner had issued a Prevention of Future Death Notice (Regulation 28).
- 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.
- We were told by managers that when necessary women and those close to them were involved in reviews they ensured that requirements under the duty of candour regulation were met. We saw from a RCA that parents had been given a verbal apology and that a duty of candour letter had been sent offering them the opportunity to participate in the investigation.

Safety Thermometer - Maternity

Maternity and gynaecology

- The Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care.It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from **perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby** and **psychological safety**.It also records babies with an **Apgar score of less than seven at five minutes** and/or those who are **admitted to a neonatal unit. The Apgar score is** an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- We did not see evidence of the use of the Maternity Safety Thermometer. The trust routinely collected some of the data required by the Maternity Safety Thermometer (**separation from baby** and **psychological safety were not collected) however, this was not publically displayed.**
- We observed that the trust was using bespoke maternity dashboards for each ward, which were not on public display, and measured outcomes based on a nursing model of care. This meant that harm specific to maternity, was not monitored in a systematic and consistent manner.
- The delivery suite dashboard measured a number of aspects of care including: escalation when deviation from normal was detected, Waterlow assessment, SBAR handover, one to one care in labour, venous thromboembolism VTE assessment, completion of fluid balance /infant feeding charts, hourly review of cardiotocographs (CTGs), completion of the partogram, invasive devices care plans, review of high risk women, and whether the woman had their call bell to hand.
- Results were between 93% and 98% for September 2015 and demonstrated that:
  - 98% of women had pressure prevention assessments completed within six hours of admission
  - 93% of food / fluid / infant feeding / hydration charts were completed
  - 98% of Waterlow assessment were completed
  - 100% of women received one to one care in labour
  - 100% of handovers were conducted using SBAR
  - 100% of VTE assessment were completed
  - 100% of women received hourly review of CTGs
  - 99% of partograms were completed according to trust policy
  - 95% of invasive devices care were plans in place
  - 99% of care plans in place and up to date
  - 98% of review of high risk women were appropriately reviewed
  - 98% of women had the woman had their call bell to hand.

Acuity Tool

- The trust was using an acuity tool to measure and respond to capacity on the delivery suite. In addition, a traffic light system had been introduced to inform the coordinator about the length of the second stage of labour. This meant that a regular assessment of the capacity of the staff on delivery suite was undertaken and could be escalated when necessary to ensure the safety of women and their babies.
- Introduction of this system was following an investigation into an incident which had resulted in a poor outcome for the baby.

Safety Thermometer - Gynaecology

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- We saw evidence that the gynaecological ward had 100% compliance with pressure damage prevention, patient observation, nutrition, hygiene and documentation. We saw evidence that VTE compliance was 100% in September 2015; this was not on public display on the ward. We did not see evidence for urinary tract infection compliance.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained. The trust's domestic staff were responsible for cleaning and we saw cleaning schedules on all wards.

- The trust provided us with environmental audits for all areas. We saw evidence that maternity services achieved 92% compliance with the ward/department cleanliness and environment audit in August 2015.
- Patients spoke highly of the housekeeping team on the maternity and gynaecology wards and told us that everything was cleaned daily and that the bathrooms and toilets were 'spotless and hygienic'.
- We saw that equipment was labelled with tags to indicate when it had been cleaned. Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentae.
- We observed overall compliance with the trust infection prevention and control policy. We saw that staff used hand gel, protective clothing and adhered to the bare below the elbow policy. However, we saw a midwife that did not use appropriate personal protective equipment when caring for a patient that was barrier nursed. This meant that there was an increased risk of the spread of infection.
- Women were offered vaccinations against influenza and whooping cough.

Environment and equipment

- An intercom and buzzer system were in use to gain entry to the delivery suite and the maternity and gynaecology wards. This meant that staff could identify visitors and ensure that women and their babies were kept safe. However, visitors to the gynaecology ward had to walk through the postnatal ward to gain access to the gynaecology ward. This meant that, at times, the privacy and dignity of postnatal women was challenged.
- We observed that the temperature on the maternity unit was 27.6°c. This was above the recommended temperature of 25°c at which to safely store some medicines. Staff told us that prior to 8 December 2015 the temperature was below 25°c.
- We found equipment was clean and fit for purpose. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- Resuscitation equipment was checked daily to ensure equipment and supplies were complete and within date. This meant that equipment was ready for use.
- There were patient information boards on the maternity ward and on the gynaecology ward with patient information that were visible to visitors which did not protect patient confidentiality.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures.

Medicines

- Medicines including controlled drugs were mostly safely and securely stored. Controlled drugs are medicines which require additional security. On the gynaecology ward the controlled drugs were not stored in a separate locked cupboard. We brought this to the attention of senior staff and found that this had been rectified when we made our unannounced visit.
- Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct.
- The trust used electronic prescribing. Staff we spoke with told us that the Wi-Fi access in the maternity wing was intermittent which meant that access to prescription charts was inconsistent and this meant that patients did not always receive medicines in a timely manner. However, there were no maternity incidents reported between September 2014 and August 2015 relating to this concern. The trust was managing this risk at a corporate level.
- Temperatures of refrigerators used to store medicines were monitored daily. This ensured that medicines were maintained at the recommended temperature. This meant that medicines were stored correctly and that women and babies were not at risk of the administration of ineffective medicines.
- The temperature of the clinical room, where intravenous fluids were stored was 27.6°c. The Medicine and Healthcare products Regulatory Agency state that intravenous fluids should not be stored above 25°c. This meant that fluids for intravenous infusion were not stored safely putting patients at risk. We reported this to staff who reported the issue to the maintenance department. Following our inspection, the trust informed us that the high temperature was found to be caused by a broken fan. The fan was replaced and the airflow redirected on 18 December 2015. The trust also implemented documented daily temperature checks.
- We noted that 20 bags of glucose for intravenous infusion were one year out of date. We brought this to the attention of the midwife in charge of the ward who contacted pharmacy to arrange removal and replacement.
- We observed medicines stored in the anaesthetic room that, although correctly labelled, had been prepared the

day before our inspection. We found that the anaesthetic room was unlocked which meant that medicines, syringes and needles were not secure. We were told that there were plans to provide a swipe accessed lock to the anaesthetic room in January 2016.

- We found out of date medicines including Syntometrine (a medicine used in the delivery of the placenta) that had expired in 2014, Pancuronium (a medicine used by anaesthetists) that expired in March and October 2015 and glucagon that had expired in December 2014. We found two other out of date medicines, Co-amoxiclav (an antibiotic) and frusemide (a medicine to reduce fluid in the body) on the maternity ward.
- The drugs identified as out of date were removed by the end of our announced inspection. Following our inspection the trust assured us that all drugs and fluids had been checked and no more out of date stock was found. The trust also implemented a documented weekly check of all drugs and fluids on Orchard ward, delivery suite and obstetric theatres.
- We saw that venous thromboembolism (VTE) scores were monitored and recorded in women records on the maternity and gynaecology wards. VTE is the term given to blood clots. In November 2015 the VTE score for maternity was 100% and the VTE score for gynaecology was 94.6%. Treatment to prevent blood clots was prescribed and administered in accordance with the trust policy.

Records

- We saw that there were unsecured paper patient records on the gynaecology and maternity wards. We reported this to the trust and following our inspection the trust provided assurance that the storage of records had been reviewed.
- We reviewed 17 sets of maternity records and 14 sets of gynaecology records that confirmed record keeping was of a satisfactory standard.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. However, we saw that HSA1 and HSA4 forms were not always completed correctly or within the required time scale. We saw that staff had been reminded about the legal obligation and that the consultant carrying out the procedure was required to complete and return the Abortion Notification to the Department of Health within two weeks from the date of operation. We did not see evidence of how assurance would be provided of compliance with this legal requirement.

Maternity records

- At the time of our visit, women did not carry handheld notes until 20 weeks of pregnancy and therefore women and healthcare professionals did not have access to their records until this time. We were told this was to enable case notes to be reviewed by the doctors for women who were assessed as high risk and for the results of routine blood tests to be entered into the notes. The trust acknowledged that this situation did not represent best practice. Following our inspection the trust told us that a new green book process had been implemented to provide improve access to records for women and healthcare professionals.
- We saw that records were not securely stored on the delivery suite. On the maternity ward patient records were stored in an unlocked trolley adjacent to the nurse's station. This meant there was a risk confidential information could be accessed by unauthorised people.
- On the maternity unit we saw individual maternity records reviewed as part of the women's care and the personal child health record (red books) were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.

Gynaecology records

- We saw that there were unsecured patient records on the gynaecology ward. Patient records were contained in boxes in a storage unit on the main corridor of the ward. This meant there was a risk that confidential information could be accessed by unauthorised people.
- We reviewed five sets of records and saw that appropriate assessment, planning and evaluation was taking place.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect. This reflected up to date safeguarding legislation and national and local policy.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.

Maternity and gynaecology

- We were told by senior staff that all midwives and maternity care assistants had access to level 3 safeguarding children training in line with the intercollegiate document (2015). Updates at level three were provided annually at the mandatory clinical skills update week. Safeguarding training compliance at level three was recorded at 100% for midwives, nurses and maternity care assistants. This met the trust target of 90%.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- A baby tagging system was in use to ensure the safety of babies in the maternity unit. We saw evidence that in October 2015 there was one occasion where there were insufficient numbers of tags which meant a baby was unable to be tagged. The trust was in the process of purchasing more baby tags to ensure that all babies were tagged whilst in the unit. On our unannounced visit we saw that there were sufficient tags for babies including times when twins may be on the ward. We were told by staff that an audit of baby tags was undertaken three times a day and was led by the manager for each shift.
- We observed that the gynaecology ward was accessed via the postnatal ward. An additional entrance was located at the end of the gynaecology ward which had an alarm that was triggered by the baby tagging system. Staff told us that the alarm was disabled temporarily when admitting patients via this entrance. This could put babies at risk of abduction. However, patients on both the maternity and gynaecology wards told us they felt safe and secure.
- We were told by senior staff that the capacity of the safeguarding team in maternity services was under review and plans were in place to create a role for supporting vulnerable women such as those with substance misuse or peri-natal mental health concerns.
- A flag showed on the maternity service information system altered staff to any woman with a safeguarding concern in place. Safeguarding plans were also uploaded to the information system.
- We were told that learning from serious case reviews was monitored by the safeguarding team and discussed at the trust wide safeguarding children and young people board, with maternity updates at the mandatory clinical skills update week. Senior staff told us that learning from an incident relating to a woman with severe mental health issues had resulted in mental health training for midwifery and medical staff on the mandatory clinical skills update week.
- Maternity staff used an information sharing form to inform the safeguarding team and external agencies such as GP and health visitors when there were safeguarding concerns.
- We saw evidence of a pre-birth planning template in use between the trust and Bedfordshire Local Authority. This enabled staff in maternity services to manage safeguarding concerns and formulate a multi-disciplinary management plan for women and their babies where concerns existed.
- Training was ongoing to safeguard people at risk of and treat those affected by female genital mutilation (FGM). During our inspection, the trust was unable to provide evidence to demonstrate how many staff had been trained. However, after the inspection the trust told us that 126 midwives, 28 midwifery care assistants and seven nurses had completed the training.
- We were told of and saw evidence of systems in place to monitor the disclosure of domestic abuse by midwifery staff in line with NICE guideline [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded. Senior management told us that compliance with this was poor and in response the safeguarding team were planning a monthly audit to improve compliance.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). We spoke with senior staff about the provision of safeguarding supervision and were told that the trust did not provide this for staff working in maternity services. We were told that safeguarding supervision was a recommendation from the CQC “Review of health services for Children Looked After and Safeguarding in Bedford Borough” (inspected May 2015 and published September 2015) however the trust had not yet taken action to develop a formal process. We were told that a peer review session had been offered to midwives but uptake was poor but we did not see evidence of compliance with supervision. Following our inspection, the trust informed us that safeguarding supervision commenced in December 2015.

- Recommendation 2.11 from the CQC Review of health services for Children Looked After and Safeguarding in Bedford report supported our findings: 'All midwives have rapid access to ad hoc safeguarding advice and support which is well valued. However, formal group supervision arrangements with consistent attendance are not fully in place with the opportunity for practitioners to reflect on their cases. We saw limited evidence of safeguarding supervision or action plans recorded in notes. Capacity of the safeguarding team within midwifery is impeding progress in improving safeguarding practice, and governance'.
- The recommendations for the maternity services from this report included improving documentation particularly around disclosure of domestic violence; midwifery presence at GP safeguarding meetings; and that arrangements for specialist midwifery access were reviewed to take account of vulnerabilities at all levels and ensure appropriate support was available.

Mandatory training

- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality and diversity, fire prevention, infection control, learning disability awareness, load handling, and positive mental health. Midwives and midwifery managers were 91% compliance with mandatory training. This met the trust target of 90%.
- Specific maternity mandatory training took place over a week and covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping. 98% of midwives and 100% of nurses and maternity care assistants had undertaken new-born life support training. 95% of midwives and 100% of nurses and maternity care assistants had undertaken infant feeding training. 95% of midwives, 86% of nurses and 85% of maternity care assistants had undertaken record keeping training. The trust told us that all staff that had not received specific maternity mandatory training had been booked to attend a maternity training session at the beginning of 2016.
- Staff told us that the content of the maternity specific study days were changed annually to reflect incidents that had taken place.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse.
- The CTG machine was used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. We saw that staff were required to undertake CTG training annually and that 92% of staff had completed the training. We also saw that 98% of staff had attended a CTG update. However, this was recorded as 100% on the Clinical Performance and Governance Score Card.

Assessing and responding to patient risk

- For women using maternity services the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit. Between July and September 2015, 94% of women were booked by 10 weeks and two days gestation of pregnancy. We saw that an on-going risk assessment was carried out at subsequent antenatal visits and referral to the obstetric team made if risk factors were detected.
- Women who had problems in pregnancy were reviewed on the DAU or the delivery suite depending on their clinical presentation and level of risk. From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy.
- High risk women were expected to be scanned every two weeks. We saw evidence that staff found it hard to make scan appoints for women as the trust only had the capacity to scan at 30, 34 and 38 weeks. There was a risk this would delay the detection of poor growth in babies.
- **Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman.**

We saw evidence of a guideline for management of sepsis in the obstetric patient that helped staff identify women at risk of sepsis and initiate required treatment.

- **We were told that the critical outreach team supported midwives with the care and management of critically ill women.** Any woman who needed additional support and care was transferred to the intensive therapy unit (ITU).
- **There was not a dedicated high dependency area within delivery suite. Women were cared for in room 1 which was also used as a temporary theatre.**
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery' guidelines. We saw evidence that all the stages were completed correctly and that checklists showed that this was usual practice.
- NHS Safety Alert 1229: Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used. We saw compliance with swab counting was 100% for delivery suite theatre in September 2015. Compliance with swab counting was 99% after delivery of the baby and 100% after a woman had perineal sutures in 2014. This meant that women were protected from the risk of a retained swab.
- The senior midwives on duty provided a CTG review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that it was within normal parameters.

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- Calculations were made using Birthrate Plus® methodology for midwifery staffing using antenatal, postnatal, cross border and place of birth data collected between April 2014 and the end of March 2015. The trust required 109.6 whole time equivalent (WTE) clinical midwives and there were 98.8 WTE in post. Birthrate Plus® methodology allowed for maternity support workers and registered nurses to be factored into calculations and there were 10.8 WTE such staff supporting midwives. This meant that there was a midwife to birth ratio of 1:30.
- Midwives worked a mixture of eight hours and 12 hour shifts. We saw that the band 7 delivery suite coordinator was mostly supernumerary and coordinated the activity on the ward. Labour ward coordinators required constant oversight of the ward so that decisions could be made regarding care and treatment.
- We were told that in times of increased activity, coordinators may have to care for women in labour. We saw evidence that the coordinators had been supernumerary for 46% of their time. Following a SI this had increased to 83%. There was a risk that this could reduce the safety of women in labour as the co-ordinator needed to have an overview of activity at all times in order to manage the ward safely.
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. The delivery suite required seven midwives and two maternity support workers (MSW) on each shift. We saw that required and actual staffing on the delivery suite was met on this ward during our inspection.
- Staffing requirements for the maternity ward was four midwives, one registered nurse and two MSWs on the day shift; three midwives, one registered nurse and two MSWs on the late shift; and two midwives, one registered nurse and one MSW on the night shift. We saw that required and actual staffing was not met on the ward during our inspection. There was only one MSW on the late shift and two qualified staff on the night shift. This had not been escalated.
- The DAU was run by one midwife and a support worker. Staff told us that it was difficult to take meal breaks.
- On our unannounced visit, we saw that surgical outliers had been sent to the maternity ward overnight. We asked who had been on duty overnight on the maternity ward and saw that two midwives and a registered nurse were on duty. The registered nurse was allocated to the maternity ward but moved to delivery suite to scrub in

the event of an emergency caesarean section or other operative emergency. This meant that there was a risk that surgical patients may not be cared for by staff with the appropriate skills.
- Between April and December 2015 the midwifery sickness rate was 6.1%. This did not meet the trust target of 3.25%.
- The maternity unit did not use agency staff and had its own bank of temporary staff. This was made up of permanent staff who undertook extra work to cover shortfalls. Whilst this improved safety because staff were familiar with the service, there was a risk that overtired staff could be providing care.
- Each full time community midwife had a caseload of 88 patients which was better than the recommendations by Birthrate Plus® of one midwife to 96 patients.
- There was a lone worker policy which community midwives adhered to.
- Midwifery hand over took place at the change of each shift. Handover included a review of all women on the wards and allocation of work. We observed that the midwifery handover on the delivery suite was organised and systematic.
- Formal multi-disciplinary handovers were carried out four times during each day on the delivery suite attended by medical staff and the labour ward coordinator. We observed the 8.30am handover which was structured and included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate doctor.

Nursing staffing

- The gynaecology ward had 10 beds and treatment room used by ward attenders.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse for eight patients. We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift.
- In November 2015 the average staff fill rate was 90% on the gynaecology ward. This was below the trust target of 95 but the trust managed the risk through the use of bank/agency staff or reallocation of staff from other areas as deemed appropriate by senior nurse managers.
- Nurses rotated to the gynaecology outpatient clinic. There was a nurse colposcopist and a cancer specialist nurse for gynae-oncology who cared for women with ovarian cancer.

Medical staffing

- The trust employed 16 WTE medical staff in the maternity and gynaecology services. The level of consultant cover was 43% which was better than the national average of 35%. The percentage of registrars 43% which was fewer than the national average of 50%. The percentage of middle grade doctors was 1% which was fewer than the national average of 8%. There were 12% junior doctors which was greater to the national average of 7%.
- There were 60 hours of consultant cover per week on the delivery suite from January 2014 to June 2015. At the time of the inspection the consultant staff stayed on the delivery suite every day from 8am until 7pm, Monday to Friday and from 8am until 10.30am on Saturdays and Sundays. The consultant on-call for the week provided out of hours cover.
- A consultant anaesthetist provided cover for delivery suite between 9am and 5pm weekdays. Out of hours cover was provided by two specialist registrars who were supported by the on-call consultant.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- The gynaecology service was covered by a junior trainee and a registrar who were also on duty for obstetrics and related gynaecology emergencies in the emergency department.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff.
- DAU medical cover was provided by obstetricians from the on call team and staff told us that delay in medical review impacted on timely management and treatment for patients.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

Overall we rated the service as good for effective.

Care and treatment reflected current evidence-based guidance.

Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care.

Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care. However, the results of monitoring were not always used effectively to improve quality. For example we saw little progress in the reduction of the caesarean section rate.

Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.

Staff were mostly competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

Evidence-based care and treatment: Maternity

- 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. Hard copies were also available in ward areas.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- We found from our discussions and from observations that care was provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- We found evidence to demonstrate that women were cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was mostly managed in accordance with NICE Quality Standard 132.
- We saw that there was a vaginal birth after caesarean section (VBAC) pathway aimed at reducing the caesarean section rate. A clinic was held by the supervisors of midwives. The results of an audit based on a case note review of 30 women who had their babies between August 2014 and January 2015 demonstrated a normal birth rate of 80% for women with a previous caesarean section.
- There was evidence to indicate that NICE Quality Standard 37 guidance was adhered to in respect of postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Minor gynaecological surgery was undertaken on a day case basis. The expectation was that the woman went home on the day of the procedure. Women we spoke with told us they had received good care and they had been informed about their discharge home.

- We saw evidence that the trust had introduced technology into the nurse led colposcopy service (DySIS digital spectroscopy). The trust was also the co-ordinating centre for a large multi-centre patient satisfaction survey on the use of this technology.
- The trust offered a total laparoscopic hysterectomy service, a minimally access surgery that was soon to be a performance metric in endometrial cancer management, to all suitable patients.
- Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Women could choose to have early medical abortion (EMA), late medical abortion or surgical treatment under local or general anaesthetic.
- RCOG Clinical guideline No. 7 advises that information about the prevention of sexually transmitted infections (STI) should be made available. All women under 25 were tested for chlamydia infection prior to any treatment (chlamydia is a sexually transmitted bacterial infection). Women with positive test results were referred to sexual health services. Women were also referred to sexual health services for further screening for other STI and treatment.
- We saw evidence that blood was tested at the initial assessment to determine rhesus factor and anti-D immunoglobulin administered to women who were found to be rhesus negative.
- We saw evidence that contraceptive options were discussed with women at the initial assessment and a plan was agreed for contraception after the abortion. These included long acting reversible methods (LARC) which were considered to be most effective as suggested by the National Collaborating Clinic for Women's and Children's Health.
- Women undergoing medical abortion were asked to ensure that a pregnancy test was completed after two weeks post procedure to ensure that the procedure had been successful.
- A discharge letter was given to women providing sufficient information to enable other practitioners to manage complications in line with Department of Health RSOP 3: Post procedure.

Audit

- The trust provided us with the clinical audit plan for 2015/16 which showed 18 obstetric audits and two gynaecology audits listed.
- Examples of audits included gestation related optimal weight (GROW), new-born and infant physical examination (NIPE), SBAR, satisfaction with labour, and record keeping. We saw that data was not consistently analysed and that recommendations and action plans were not always made as a result of audits.
- The trust actively participated in national audits such as the National Screening Committee Antenatal and Newborn Screening audit. The trust met five of the six key performance indicators (KPI) for antenatal screening and four of the six KPIs for neonatal screening. The trust had an action plan in place to the outcomes that were not met, including additional staff training.
- The Morecambe Bay investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital. The report made 44 recommendations for the trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw evidence that the trust had carried out a gap analysis to benchmark the service against the findings of the report and assessed that it was compliant with recommendations. Evidence was supplied to support compliance. However, we were not assured of a robust approach. For example actions two and three of the plan stated that an audit would be undertaken to review the staff perception of the culture and working relationships within the maternity unit. We saw that this was commissioned internally by the trust in June 2015 but only 20% of staff working in maternity services had been surveyed. This meant that we were not assured that culture within the unit had been fully explored.

Pain relief

- Women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including transcutaneous electronic nerve stimulation (TENS) machines and Entonox, a ready to use medical gas mixture of 50% **nitrous oxide** and 50% oxygen that provides short term pain relief. Epidurals were available 24 hour a day.
- A birth pool was available in the midwifery led rooms on the delivery suite so women could use water immersion for pain relief in labour.

Maternity and gynaecology

Nutrition and hydration

- The quality and governance midwife was also responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- The trust had been awarded and maintained UNICEF Baby Friendly Initiative stage three accreditation. This meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- 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%.
- The trust offered a midwife led tongue tie division service which was supported by the infant feeding team and the oral maxilla facial surgeons. This meant that women and babies received timely intervention when feeding was complicated by tongue tie (a condition where the string of tissue between the baby's tongue and floor of the mouth is too short and affects the baby's ability to latch onto the breast casing feeding problems). We saw documentary feedback for this service. One patient commented 'Very impressed with level of support and compassion shown to us during the new exciting and emotional time. We cannot fault anything about the service we experienced. Infant feeding team was fantastic'.
- Women who chose to bottle feed their babies told us that they were offered support in their choice and that they did not feel pressurised into breast feeding their babies.
- There was a shared dining room for the maternity and gynaecology ward. In relation to meeting their nutritional needs patients were able to choose from a varied menu, which also met their cultural requirements.
- Patients told us, and we saw, that food was available outside of set meal times if they did not feel like eating or were unable to eat at set meal times. One patient we spoke with was concerned that she had to leave her baby unattended to go and get food. However, another patient told us that staff 'brought food to my bed'.

Patient outcomes: Maternity

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The maternity dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- A Clinical Performance and Governance Score Card was used for recording activity and outcomes. However, quality data was not matched against other indices such as staffing, number of incidents and complaints. This meant that the trust could not effectively monitor issues such as clinical outcomes in times of shortage of staff.
- October 2015 quality data demonstrated that:
  - The normal delivery rate was 61%, which was similar to the RCOG recommendation of 60%.
  - The homebirth rate was 3% which was higher than the national average of 2.3%.
  - In October 2015 the caesarean section rate was 30%, worse than the national average of 25%, of which 10% were elective caesarean section and 20% emergency caesarean sections. This compares to the national average for elective caesarean section of 10.7% and the national average for emergency caesarean sections of 14.7%.
  - The induction of labour rate was 24%, which was similar to the national average of 22%.
  - In October 2015 the instrumental delivery rate was 9%, of which 3% were ventouse and 6% forceps deliveries. The national average for ventouse delivery was 7% and the national average for forceps delivery was 5.8% (2014).
  - There were six third or fourth degree tears recorded which equated to 2% of patients.
  - The trust recorded postpartum haemorrhage above 2.5 litres on the Clinical Performance and Governance Score Card and there was one such haemorrhages in October 2015.

- Other clinical data normally recorded on a maternity dashboard for example postpartum haemorrhage and unexpected term admissions to the neonatal unit were not recorded on the Performance and Governance Score Card. Review of the maternity incidents between September 2014 and August 2015 showed the following outcomes:
  - There had been one maternal death in 2015.
  - 197 women had experienced a postpartum haemorrhage up to 1000mls.
  - 79 women had experienced a postpartum haemorrhage of over 1000mls, one of which was 2500mls (June 2015) which was not recorded on the Performance and Governance Score Card.
  - 30 women sustained a third or fourth degree tear to the perineum.
  - At the time of our inspection, we found it hard to determine how many babies who had died either in the ante natal period, in labour or shortly after birth. We found that six babies had died antenatally, two died in labour and seven neonatal deaths. The trust later confirmed that in 2014/15 there were six stillbirths and 11 neonatal deaths, and between 1 April and 30 December 2015 there were seven stillbirths and nine neonatal deaths.
  - 171 babies were unexpectedly admitted to the neonatal unit (NNU). We saw evidence that the admission of term babies to the NNU was 61.5% (perinatal meeting July 2015).
  - Babies were admitted for management of low blood sugar, temperature regulation or jaundice. We were provided with data that showed 10 babies had been admitted for weight loss management however review of the incidents between September and December 2015 only contained four such babies listed as incidents.
- The latest CQC Intelligent Monitoring report (May 2015) found no maternity outliers for the trust.
- The trust met two of the five standards in the National Neonatal Audit Programme 2013. The trust almost met the remaining three benchmarks and standards. The trust met the standards for the percentage of babies who had their temperature taken within the first hour of birth (100% compared to a standard of 98%), and the percentage of mothers who received a dose of antenatal steroids (88% against a standard of 85%).[1]

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients during the week. A team of professional staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours. We were told that there was a gynaecology operation scheduled on most days.
- The trust provided activity data for April to September 2015 that demonstrated the following:
  - 2766 GP referrals
  - 858 other referrals
  - 402 consultant to consultant referrals
  - 1723 new outpatients
  - 1912 follow up appointments
  - 3146 outpatient procedures
  - 432 day case
  - 337 elective operations
  - 322 emergency operations
  - 386 medical or surgical terminations of pregnancy
  - 15 medical terminations
- Patients were offered a choice of medical or surgical treatment for termination of pregnancy. There were four theatre slots per week available for surgical termination of pregnancy. We saw that consent forms were completed appropriately. The patient's GP usually signed Part 1 of the HSA1. Alternative systems were in place for obtaining a second signature if the GP had not completed the form.

Competent staff

- Maternity specific mandatory training and other learning and development were managed by the practice development midwife.
- An induction period of four weeks and six week supernumerary status was offered to newly appointed or newly qualified staff.
- In addition, all newly qualified midwives undertook a 12 month preceptorship period prior to obtaining a band 6 position. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service. Staff told us they 'felt confident to practice'.
- Appraisal rates for staff demonstrated that 95% of midwives had been appraised.
- Royal College of Anaesthetists (2011) recommended that practitioners, who undertake recovery duties post-surgery, must meet specific criteria in achieving their competencies. We saw evidence that midwives

were not meeting these criteria and that the supervisors of midwives team had supported midwifery management in submitting a business case for approval.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:14 (LSA Report 2014) which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- Junior doctors reported very positive feedback on training and the support they received from the obstetrics and gynaecology consultant team.

Multidisciplinary working

- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.
- We were told of multidisciplinary links with external trusts. For example for women requiring investigation and ongoing management for foetal abnormality and women with gynaecological cancers.

Seven-day services

- Access to medical support was available seven days a week. The early pregnancy service ran weekday mornings but if necessary early pregnancy scans could be done at weekends by the on call consultant or a radiologist could be called in by the on call consultant.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides, policies and procedures to assist in their specific role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the procedure of consent was reviewed prior to surgical procedures which was good practice.
- Consent was for termination of pregnancy was appropriately and correctly obtained in line with Department of Health RSOP 8: consent. Consent was obtained at the assessment visit and again on the day of treatment.
- Midwives and nurses who were required to complete the three yearly Mental Capacity Act 2005 training were 71% compliant. Compliance did not meet the trust target of 90% and meant that staff who had not received the training many not have the appropriate skills to care for patients under the Mental Capacity Act 2005.
- Staff told us that mental capacity was assessed by medical staff prior to gaining consent.

Are maternity and gynaecology services caring?

Good

Overall, we rated the service as good for caring.

Feedback from patients and those close to them was positive. Patients told us that they felt safe. Staff treated patients with dignity, respect and kindness during all interactions and patient-staff relationships were positive.

Patients were involved and encouraged to be partners in their care and were supported in making decisions. Both maternity and gynaecological patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

Midwifery responded compassionately when patients needed help and supported them and their babies to meet their personal needs. Staff helped patients and those close to them to cope emotionally with their care and treatment.

Patient's spoke very highly of the nursing staff on the gynaecology ward; describing them as 'exemplary'.

Maternity and gynaecology

Compassionate care

- Maternity services were added to the Friends and Family Test (FFT) in October 2013. Between July 2014 and August 2015 a high percentage of patients recommended the antenatal services, postnatal ward and birth services. The scores were similar to the England average. More than 90% of patients recommended each of the services in every month apart from one (antenatal services in July 2014). The percentage of respondents recommending the postnatal community service ranged between 87% and 100% for the period, with the best score achieved in August 2015.
- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 120 women returned a completed questionnaire. It showed that most outcomes were similar to the national average. The trust scored better than other trusts' in two areas; **advice at the start of labour and reasonable response time during labour** and 'about the same as other trusts' in the remaining 16.
- We observed caring and compassionate interactions between staff and women. Patients told us the staff were 'friendly and welcoming'.
- One patient told us that staff in the antenatal clinic were 'compassionate' and that they were given the time they needed.
- One relative spoke with us about the care of their relative on the gynaecology ward: 'They (staff) have been looking after my relative really well, could not have had better treatment if she was in the best private hospital or we had all the money in the world'.
- Another relative told us that the staff on the gynaecology ward provided 'patient centred care' and that the patient had been treated as an individual: 'the staff were wonderful, every member from housekeepers, receptionists, nurses, sisters to doctors'.
- Patients told us that nurses closed the curtains and spoke in a low volume to them on the gynaecology ward. This indicated that staff were respecting patient's privacy and observing confidentiality.
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. Partners of pregnant women told us that they felt included and well informed.
- Partners of maternity patients described feeling involved in the care provided. One father told us that they were involved in all decisions. They cut to cord at the birth and 'felt part of the team'.
- A patient's husband told us that staff on the gynaecology ward had taken time to explain everything and answer questions at a very difficult time and that he was included in decision making.

Emotional support

- Bereavement support was offered by midwives. Memory boxes were provided to parents who had suffered a pregnancy loss. Chaplaincy support was available.
- Counselling for termination of pregnancy was not provided at the trust. Staff referred women to their GPs if they requested support.

Are maternity and gynaecology services responsive?

Requires improvement

Overall we rated the service as requires improvement for responsive.

Services did not always meet people's needs.

Patients' individual needs and preferences were not considered when planning and delivering services. The facilities and premises on the gynaecology ward were not appropriate for the services provided. The gynaecology ward was accessed through the maternity ward. An alternative entrance ward existed but this was not accessible for people with disability or those on trolleys.

The gynaecology ward had outliers that impacted on the care provided to women with gynaecological conditions because beds were occupied with patients with medical conditions. This also impacted on maternity patients because beds on the maternity ward were used for gynaecology patients and in some instances surgical patients so that the gynaecology ward could take outliers. We did not see any action taken to address this issue.

Maternity and gynaecology

The maternity service was flexible and provided choice and continuity of care.

The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs.

Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- The trust had introduced a self-referral system for women seeking treatment for termination of pregnancy.
- We observed that the gynaecology ward was located at the end of the maternity ward and the wards had a shared entrance. An additional entrance was located at the end of the gynaecology ward which could be accessed by stairs only. Gynaecology and maternity patients shared the dining room. Staff told us that this was the previous arrangement and that the gynaecology ward was moved five years ago to the main part of the hospital. Staff were given 24 hours' notice of relocation back to the maternity unit.

Access and flow

- The proximity of the gynaecology and maternity ward enabled 'flexing' of the beds to accommodate gynaecology patients and outliers. Staff told us that this was a frequent occurrence and that the day before our inspection gynaecology patients had occupied the side rooms and a four bedded bay on the maternity ward. This meant there was a risk that postnatal women could not be cared for on the ward. We did not see that such incidents had been reported.
- Staff told us that the bed managers tended to admit pregnant women with medical conditions to the gynaecology ward. We saw two obstetric patients were cared for as medical outliers on the gynaecology ward. One patient was 38 weeks pregnant and had been admitted with chest pain and atrial fibrillation. We spoke to a member of nursing staff who stated that it was usual practice to admit pregnant women who were under a medical speciality to the gynaecology ward however, they were unable to confirm if the obstetric team knew of the patient. Another patient who was 19 weeks pregnant had been admitted with chest pain. We were told that a medical outlier's handover sheet was stored on delivery suite so that staff in maternity services knew of pregnant patients admitted elsewhere in the hospital. We reviewed the sheet and found that this contained information on only one of the women on the gynaecology ward.
- We made an unannounced visit and found that the DAU had been used overnight for two gynaecology and two surgical patients due to lack of capacity on the gynaecology ward. The impact of this was that the DAU could not open for pregnant women and therefore, they were transferred to labour ward. Staff had to transfer all the necessary equipment and the hand held phone. The DAU was vacated by 1pm and subsequently, the service moved back.

Maternity

- The maternity unit had not closed between January 2014 and June 2015.
- Women could access the maternity service via their GP or by direct referral. We saw that 94% of women were seen by a midwife by 12 weeks and six days of pregnancy. NICE guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening for Down's syndrome, which must be completed by the 13 weeks and six days of pregnancy, can be arranged in a timely manner.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place to give birth. This decision was made when they were 34 weeks pregnant and information was provided to assist in making their choice. We saw that specific risk factors were taken into account which needed to be considered and would lead midwives to advise a hospital rather than a home birth.
- The DAU provided an assessment service to women over 20 weeks of pregnancy between 7am and 9.30pm Monday to Friday, and 8am and 6pm on weekends on an appointment basis. Women were seen on the triage unit out of hours. Women could be referred to the DAU

by community midwives, GPs, or they could self-refer. Day care was available for women with concerns such as reduced foetal movements. Induction of labour was also managed on the DAU.

- Between 18 and 32 women could be seen on DAU. Women for induction who were considered low risk were given a prostin pessary used to induce labour on the unit and were then sent home to return six hours later for assessment and onward treatment.
- There was a designated triage room on labour ward where women with urgent concerns could be reviewed and assessed. Women were provided with the telephone number for delivery suite and a midwife was allocated to work the triage room on a daily basis.
- We saw evidence that 94% of women who attended triage were seen by a midwife within 30 minutes of arrival and 61% of women were seen by a doctor within 60 minutes of arrival between October and November 2015. The trust had an action plan that included:
  - Share data with all maternity staff
  - Raise awareness of importance of early triage and review by medical staff if needed
  - Importance of recording when women reviewed on activity flow chart'
- However, this was not a formal action plan and did not contain dates for actions to be achieved or identify staff responsible.
- Elective caesarean section lists ran each weekday morning.
- At times, one of the delivery suite rooms, room 1 was used as an emergency theatre because the obstetric theatre was in use. This was equipped with anaesthetic equipment and an appropriate scavenging system. We saw evidence that this had been used for emergency caesarean sections eight times since January 2015.
- Staff told us that it was sometimes difficult for women to get appointments for ultrasound due to lack of capacity. We saw that four incident reports had been submitted between August 2014 and September 2015 regarding scan capacity. This meant that there was a risk that women requiring scans for fetal growth assessment or as part of the stillbirth prevention pathway may not be seen in a timely manner.
- We noted that quarterly bed occupancy ranged between 54% and 89% between April 2013 and June 2015. This was above the England average of between 55% and 60% for all quarters except April to June 2015.
- Data from the 2013 Maternity Experience Survey found that patients reported the response time to the call button was in line with England average, scoring 8.2 out of 10.

Access and flow: Gynaecology

- An early pregnancy assessment unit (EPAU) was located in the antenatal/gynaecological clinic and offered appointments between 8am and 4pm each weekday. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs, nurse practitioners and the emergency department. There was access to scans and medical opinion was accessible from the on call registrar.
- We saw that there two outliers (patients who were not nursed in a specialist area for their particular condition) on the ward on one occasion during our visit. Staff told us that outliers increased during winter pressures and could affect care provided to women with gynaecological conditions.
- We saw that 91% of patients that required admission were admitted within 18 weeks which did not meet the trust's referral to treatment (RTT) target of 93%. The average waiting time for patients requiring admission was zero to six weeks.
- The trust provided us with information that showed 21 (0.5%) gynaecology operations were cancelled on the day of surgery between April and September 2015.
- The trust had established an ambulatory gynaecology service for outpatient procedures under local anaesthetic that included myosure, novosure, and operative hysteroscopy.
- Nurse led colposcopy and hysteroscopy was offered on an outpatient basis

Meeting people's individual needs

- We saw that there was a separate entrance to the gynaecology ward that enabled patients to access the ward without going through the postnatal area which meant that women who were experiencing pregnancy loss did not have to see mothers and babies. However, this route could only be accessed by stairs which meant that women with physical disability or those on trolleys could not access this sensitive entry to the ward.

Maternity and gynaecology

- We saw that the antenatal clinic and gynaecology outpatients shared accommodation. One patient told us that she found it distressing and insensitive that infertility clinics were held at the same time as antenatal and gynaecology clinics.
- Patients told us, and we saw, that there were not any toys or books provided for children of patients in the waiting room.
- Women with complex requests or needs, for example requesting home birth when risk factors were present, held discussions with the supervisor of midwives and a plan was then developed.
- The trust ran a diabetic clinic to support women throughout pregnancy.
- Specialist midwives for diabetes, screening and safeguarding who had completed additional training, gave advice and support to women and midwives.
- There was not a specialist team for vulnerable women or those with psychiatric illnesses. Staff reported that the psychiatric liaison service was very responsive but that they would like support from a dedicated team to pick up signs of mental health problems and provide women with support.
- A midwife with special responsibility for women who had refugee status or were seeking asylum was in post and had gained security clearance for a nearby detention centre. This meant that women were able to receive timely midwifery care.
- We saw that there were effective processes for screening for fetal abnormality. Women identified with a high risk of fetal abnormality, such as Downs's syndrome, were invited into the clinic for on-going treatment and referral to specialist centres if appropriate.
- Partners could visit between 8am and 9pm on the maternity ward. Other people could visit at fixed times. This enabled new parents to spend private time with their babies. Staff told us that partners were able to stay overnight in the side rooms on recliner chairs provided but not in the four bedded bays. However, new parents told us that partners also had to leave at 9pm but were informed that a partner could stay and this would cost £65.00 per night for an amenity room.
- We saw a variety of patient information leaflets available for both maternity and gynaecology patients. However, they were not available in different languages.
- Information leaflets were available for women suffering pregnancy loss outlining the choice of expectant (awaiting events) or surgical management.
- We saw that there was an interpreter service available by telephone. Sockets were in each room on the delivery suite to make this accessible.
- There were two midwifery led rooms in the acorn suite on delivery suite. These rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour. Birth pools were located in both rooms for women who wished to use water immersion for pain relief in labour.
- 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 (RCM) Innovation Awards 2015.
- Privacy and dignity was enabled by the use of privacy screens around beds and on the entrance to rooms on delivery suite.
- Eight midwives with special interest provided care and support to women who suffered pregnancy loss from 16 weeks of pregnancy as part of their substantive role. Such families were cared for in a designated bereavement suite, the butterfly room. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents who suffered pregnancy loss. A remembrance day was held annually on the Saturday of baby-loss week.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, one four bedded bay on the maternity ward was designated for transitional care. However, we saw evidence that on occasions, babies were admitted to the on-site NNU because this facility was unavailable due to lack of capacity. This meant that babies were separated from their mothers. There was also a risk that this contributed to patient flow problems because the NNU could not accept babies needing the level of care they provided. This was not on the risk register.
- Supervisors of midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- The supervisors of midwives provided a 'listening service'. Women were provided with information about

the listening service by midwives and given a card with a dedicated mobile phone number that they could use to contact the midwives. Referrals were made by the woman (self), a hospital or community midwife, health visitor, GP and/or physiotherapists. A total of 92 referrals were received between April 2014 and April 2015. We saw evidence that the SoMs were developing a 'feedback form' to enable the further development of this service.

Learning from complaints and concerns

- Information from the trust indicated that there had been two maternity and three gynaecology formal complaints made in October 2015.
- Complaints were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the patient experience team if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Once a complaint was made, it was distributed to responsible officers for investigation and response within 25 days.
- We discussed learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint.
- Common themes ranged from communication, understanding interventions and attitude of staff. We saw evidence that the trust had stated that lessons learnt had been shared but did not describe what those lessons were or how they had been shared. We saw one example where a member of staff attended diversity training following a complaint.

Are maternity and gynaecology services well-led?

Requires improvement

Overall we rated the service as requires improvement for well-led.

There was a statement of vision and strategy. However, staff we spoke with did not demonstrate awareness or understanding of it.

There were fragmented governance structures. Quality data was recorded on the management information system and reviewed to identify trends and aid forward planning. However, we were not assured that robust analysis was taking place. The trust did not use a maternity dashboard which meant that the trust did not have readily accessible oversight to identify patient safety issues in advance so that timely and appropriate action could be instituted to ensure a woman-centred, high quality, safe maternity service. Not all risks were identified on the risk register and we could not always see evidence of an action plan to address the issues.

There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.

Vision and strategy for this service

- We that the women's and children's directorate had a vision and strategy. This was not underpinned by detailed, realistic objectives and plans and staff could not articulate the content.

Governance and risk management

- We saw that fragmented clinical governance and risk management arrangements were in place. For example the risk maternity manager also had managerial responsibility for the community midwifery service, maternity outpatients and screening services; and the governance and quality midwife also had additional responsibility for infant feeding. This meant that there was a risk staff with multiple roles had limited effectiveness.
- The management team met weekly to review incidents which were reviewed at the monthly obstetrics and gynaecology governance group which in turn reported to the monthly trust quality board who reported to the board.
- The quarterly perinatal mortality and morbidity meeting reviewed adverse events in order to identify the causes so that steps could be taken to prevent recurrence.
- A labour ward forum met to identify areas of good practice and new evidence based practice.
- We were told that following review at the weekly meeting, significant incidents such as intrapartum

stillbirth were subject to a multidisciplinary round table review within 24 hours. The risk manager coordinated reports which were forwarded to an executive team comprised of the chief executive, the medical director and the director of nursing and patient services who decided whether the threshold for reporting to STEIS and to commissioners was met. There was not an obstetrician, gynaecologist or midwife on this group and therefore, we were not assured of the clinical maternity specific expertise in the review of maternity and gynaecology specific incidents.

- We reviewed the minutes of the obstetrics and gynaecology governance group for March to November 2015 and saw that the meeting followed a standing agenda. Issues were identified and actions were planned and reviewed. However we were concerned about how plans were executed and how sustainably was assured because there was no evidence of monitoring of plans implemented.
- We were not assured that all risks were identified. The maternity and gynaecology risk register contained two risks relating to maternity. These were midwifery staffing in maternity unit and documentation errors. There were no, gynaecology related risks recorded. We saw that progress against risks on the register was noted and that the risk register was discussed at the monthly obstetrics and gynaecology governance group meeting.
- Staff told us that they recieved feedback in various ways. Performance issues were taken up with the individual staff member. A quality and risk newsletter was available electornically and in hardcopy to share lessons learned form incidents and complaints
- Guidelines were reviewed by the quality and governance lead midwife. Guidelines were discussed at the obstetrics and gynaecology governance group meeting. We saw that all guideleines were in date.
- We were told that guidleines were updated in the light of evidence from investigations. We noted that the 2011 guidance for fetal heart rate monitoring was changed in February 2015 in response to the outcome of a SI which took place in September 2014. It was amended again in August 2015 response to the coroner's case held in July 2015.
- It was clear during our inspection that the executive team was not fully aware of all events in the maternity unit.
- Following our inspection, we were reassured to see that the trust had commissioned an external review of maternity services which will be run by a programme board using project management methodology. The review plans to explore governance structures, management structures and ways of working; undertake a diagnostic review of the culture of the unit, particularly focusing on human factors and the trust's values; undertake a review of relevant clinical quality indicators; review the leadership of maternity and how maternity services interfaces with the planned care division and the rest of the organisation; review how the service conducts clinical governance and in particular the management of SIs, incidents, complaints, the introduction of patient safety initiatives and clinical audit; and review and understand the implications of the national maternity review report once it is available.

Leadership of service

- Maternity services were led by divisional director of planned care, associate director of operations, clinical director and head of midwifery (HoM).
- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership at ward level, in particular the lead nurse on the gynaecology ward demonstrated strong leadership skills.
- Staff said that senior managers were visible and approachable. This meant that they were easily accessible to staff.
- It was unclear who was leading the directorate. The HOM was professionally accountable to the director of nursing and patient services and was line managed by the business manager of the directorate.
- The CD reported a good working relationship with the HOM, the business manager and the medical director.
- We were told that the HOM had direct access to the trust board. This meant that the board could be readily sighted on issues relating to maternity.
- Ward staff told us that the trust board were visible.
- Staff told us that one band 6 development session was held to provide band 5 midwives with supported, hands on experience of the roles and responsibilities of the band 6 position. Midwives were required to attend this in their own time.
- We saw from ward meeting minutes that managers thanked staff for their hard work and dedication to providing care for women and their babies and support for their colleagues.

Maternity and gynaecology

Culture within the service

- Staff expressed the view that 'they had had a bad year' following a maternal death and two coroner's cases.
- Midwifery and nursing staff all had a strong commitment to their jobs and displayed loyalty to senior staff.
- Staff described a very supportive team culture. They told us that they 'willingly give time but their goodwill is not taken for granted'.
- From our observations and discussions with staff we saw a strong commitment to meeting the needs of people using the service, and resilience and determination to do the best they could under the constant pressure they faced.
- Many staff we spoke with had worked at Bedford Hospital their whole career. Staff told us that they were 'proud to be working at Bedford Hospital'.
- In discussion with staff, we found evidence of discord between the consultant team. Staff expressed concern that 'honesty and transparency was missing' and that 'blame gets thrown around'. However, the 2015 staff survey and feedback from student midwives and doctors in training demonstrated a workforce that was largely positive about the management and leadership of service. For example, the trust performed well in the 2015 General Medical Council (GMC) junior doctors satisfaction survey; the GMC also identified the positive learning culture of the obstetrics and gynaecology department as a key area of good practice; and student midwives provided positive reflections on their clinical placement at Bedford.

Public and staff engagement

- There had been not been a maternity services liaison committee (MSLC) meeting since September 2014. We saw evidence that the HOM had discussed this with the commissioners and that the MSLC attended the labour ward forum on the 3 August 2015, to explore how to regain a full functioning MSLC. We could not locate evidence that this had progressed and that meetings had been held. However, we saw evidence that the SOM team would assist the trust in recruiting members of the public to join the MSLC.
- 'You said we did boards' were visible in the clinical areas which demonstrated that the trust listened to patient's views and acted on them. For example we saw the following comments:
  - You said you wanted separate areas for gynaecology and antenatal clinics. We divided the consultation rooms into a gynaecology side and antenatal side as much as possible.
  - You said you wanted an easier and quicker referral for termination of pregnancy. Patients are now able to refer themselves to the termination of pregnancy clinic.
  - You said you wanted an easier and quicker referral process for ultrasound scans. Patients are now able to refer themselves for a scan.
  - You said it was sometimes upsetting to walk through the maternity ward to get to their gynaecological ward. We had an alternative entrance made for gynaecological patients.
- We were told that a user representative sat on the labour ward forum and reviewed guidelines, which is considered best practice

Innovation, improvement and sustainability

- The trust was offering high risk women the opportunity to use water as pain relief in labour and was selected as a finalist in the Royal College of Midwives (RCM) Innovation Awards 2015.The SOMS were working to improve practice by offering a listening service for women who wanted to discuss their experience with a midwife.
- To standardise their investigations into stillbirth and intrauterine deaths, the trust started using the Mothers and Babies Reducing Risk through Audit and Confidential Enquires across the United Kingdom (MBBRACE-UK) enquiry tool used to gather information for the Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2013 as a quality measurement tool to investigate intrauterine deaths and stillbirths in December 2015.

Services for children and young people

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

Information about the service

Bedford Hospital services consisted of a neonatal unit and paediatric unit. The neonatal unit, Meadowbank, had 12 cots and included two cots for babies who required additional care, as well as one intensive care cot, used to care for babies temporarily; babies who required intensive care which was expected to be for more than 24 hours were transferred to an external level 1 unit.

The paediatric unit, Riverbank, had 26 beds, nine of which were in the paediatric assessment unit. There were also an additional four beds that operated from 8am to 8pm for day surgery patients. There was one side room for children with increased care needs which could be used for up to two patients with the same condition. There was a co-located ambulatory care unit, predominantly for same day GP referrals as well as open access for patients with long term conditions. The paediatric unit also had a dedicated outpatient's service.

The trust recorded 2,534 paediatric spells for children between July 2014 and June 2015 of which 93% were emergency, 2% were elective and 5% were day case.

There were parent facilities on the paediatric unit as well as the neonatal unit, and children's age appropriate play areas and a teenage room on the paediatric ward.

We spoke with a number of staff including nurses, doctors, support assistants as well as patients and their relatives.

We observed interactions between staff, patients and parents. We read care records, policies and procedures and other documentation as necessary. We reviewed data provided by the hospital.

Services for children and young people

Summary of findings

Services for children and young people at Bedford Hospital were judged to require improvement for safe, effective and for being well-led, and good for caring and responsive.

Incidents were not always reported and those reported were not always investigated in a timely manner. We noted that actions recorded did not always address the issues raised, in particular for staffing incidents and there was a lack of shared learning.

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. Nursing staffing arrangements on the neonatal unit were adequate to meet requirements, most of the time.

Completion of mandatory training within the service was not compliant with the trust's target of 90%, and staff had not completed other recommended training for example Advanced Paediatric Life Support. Following our inspection the trust implemented an action plan to address this.

Most staff had completed safeguarding training and there were suitable procedures in place for reporting safeguarding concerns. However, the trust policy was not always followed.

Patient dependency levels were not always assessed and observations were not always completed within agreed timeframes, as per the patient's risk assessment for patients on the paediatric unit. There were also inadequate arrangements in place to care for patients with mental health needs.

The environment was observed to be visibly clean during our inspection, although the units' own audits identified some areas of non-compliance.

Some equipment and medicines were out of date and relevant checks had not always been undertaken or not recorded. Records were suitably stored and most contained adequate detail.

A clinical audit plan had been developed for 2014/15 and 2015/16. However, a proportion of audits had not been completed, and agreed actions and recommendations did not always address the issues identified.

Policies and care pathways relating to paediatrics and neonates were up to date and had considered national guidance as appropriate.

The service used a dashboard to monitor performance, although this was difficult to read 'at a glance' and not all relevant data had been included, raw data for some outcomes were provided.

All of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff listened to them and were compassionate; and this was supported by our observations.

We found evidence of multidisciplinary support being facilitated throughout children's services and patient's individual needs were met most of the time, although some improvement was required to support patients with learning difficulties.

There were governance arrangements in place, the paediatric and neonatal unit quality group was the main meeting for paediatrics and neonates. Meetings were minuted although the level of detail was variable.

The risk register failed to consider a number of risks, including some we identified during inspection, for example staffing shortages.

Leadership worked well and staff felt listened to most of the time, but that management failed to respond to some issues raised in relation to staffing shortages.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Services for children and young people at Bedford Hospital were judged to be requires improvement for safe.

Incidents were not always reported and those reported were not always investigated in a timely way. We noted that actions recorded did not always address the issues raised, in particular for staffing incidents and there was a lack of shared learning. Serious incident investigations were undertaken and action plans developed.

Nurse staffing arrangements on the paediatric unit were not sufficient to meet demand, evidenced through rotas as well as from talking with staff and reviewing reported incidents. 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 (RCN), in 2013. We raised our concerns with the trust who took immediate and appropriate action. Nursing staffing arrangements on the neonatal unit were adequate to meet requirements, most of the time.

Most staff had completed safeguarding training and there were suitable procedures in place for reporting safeguarding concerns. However, the trust policy was not always followed.

Completion of mandatory training within the service was not compliant with the trust's target of 90%, and staff had not completed other recommended training. For example, Advanced Paediatric Life Support. Following our inspection the trust implemented an action plan to address this.

Patient dependency levels were not always assessed and observations were not always completed within agreed timeframes, as per the patient's risk assessment for patients on the paediatric unit. There were also inadequate arrangements in place to care for patients with mental health needs.

Resuscitation equipment was all in date, although some of the daily checks had not been completed. Some electrical items had not been PAT tested and some of consumable items were out of date.

The treatment room which contained some sharp items were not sufficiently secure to prevent access. We requested that this was addressed and a keypad lock was fixed on the door during the inspection.

There was no trust policy on restraint or supportive holding and staff working in the paediatric and neonatal units had not received training.

Medicines were stored securely, though some liquid items were out of date on the neonatal and paediatric unit. Controlled drugs were stored appropriately and records maintained, although unused amounts of ampules were not recorded as disposed of. We saw there had been a number of medication incidents reported during the year.

Records were suitably stored and most of the patient records contained adequate detail.

Incidents

- There were a total of 107 incidents reported within the children and young people's acute services between the period June and November 2015 inclusive. This included three incidents categorised as moderate and one as severe. All other incidents were categorised as low harm or no harm. The severe incident, although included within paediatrics was a joint incident with the maternity unit.
- The trust used an electronic incident reporting tool to report incidents. Staff we spoke with were confident in the use of the electronic system and told us they reported incidents where it was appropriate to do so. Although when the department was busy some incidents may not be reported, in particular staffing shortages. For example, we were made aware of two incidents which had occurred, one related to the positioning of a patient's naso-gastric tube and another related to a patient discharged with a cannula insitu. Neither of these incidents had been reported.
- We found that incidents were not investigated and closed in a timely way. From review of the incidents reported in June through to November 2015, 27 were closed within 14 days, 17 within 15-29 days, 12 between 30-59 days, 18 between 60-100 days, 16 between 101-161 days and investigations had not been completed for 17 incidents, some of which had been reported in June, July and August 2015.

- The trust's incident reporting policy states that incidents must be reported as soon as possible but within 24 hours.
- Review of a sample of incident summaries and actions taken indicated action taken was recorded. Although for a small number of incidents, this did not always address the concerns, in particular, staffing incidents. The trust subsequently provided us with a detailed summary of the findings from staffing incidents and actions it proposed to take.
- We reviewed an investigation report for a serious incident which had occurred during the previous 12 months. The reports provided a chronology of events and discussion around care management problems, lessons learned were recorded and an action plan developed. The report stated that the parents had been informed of the investigation and that they would be invited to a feedback meeting.
- Staff we spoke told us that they received feedback relating to any incidents they had reported or been involved with. However, most of the staff on the paediatric unit told us that there was no wider learning. Staff who worked on the neonatal unit told us about a risk report which came out monthly and that this included details of incidents which had occurred on the unit as well as lessons learned.
- The clinical governance department produced a monthly 'Quality Improvement' newsletter. This shared actions and learning from incidents, complaints and compliments. The team also produced patient safety alerts, sharing immediate learning and actions from incidents. However, the nursing staff we spoke with were unable to recall incidents which had occurred outside of their ward / unit. Some medical staff were able to tell us about incidents which had occurred on the maternity unit.
- Most of the nursing staff we spoke with were unable to tell us about serious incidents that had occurred within neonates, paediatrics or paediatric emergency department (ED).
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The majority of staff we spoke with were unable to explain what this meant.
- The trust held internal perinatal mortality and morbidity meetings. Review of the minutes for September and October 2015 confirmed they lacked detail. For example, the September 2015 minutes reported on three separate cases; one obstetric and two paediatric. Bullet point summaries were recorded and did not report which staff were involved to ensure effective mapping of the cases and possible underlying themes. One of the cases did not provide a summary of the issues identified and one point was recorded for the lesson learned, 'Any undiagnosed genetic disorder should be reported back to antenatal clinic' but there was no explanation as to the importance of this or any further information as to how this should be achieved or why it had not been in the case presented.

Cleanliness, infection control and hygiene

- We observed the paediatric and neonatal units to be visibly clean during our inspection and review of a sample of cleaning schedules demonstrated these had been completed.
- The units did not use a sticker system to identify when equipment had last been cleaned. The neonatal unit placed plastic bags over items which had been cleaned, but the paediatric unit did not have any system in place.
- Staff wore personal protective clothing as required and this was available throughout the ward areas.
- Hand gel was available at each doorway on the wards and at other points in the unit.
- There were side rooms available on the paediatric ward to care for children who had or may have had a contagious infection. The neonatal unit used allocated rooms for patients who were brought in from other hospitals or who were readmitted to the unit after a period of time at home.
- There had been no reported cases of Methicillin-resistant Staphylococcus aureus MRSA or Clostridium difficile in the preceding 12 months.
- In the 2014 CQC Children and Young People's Survey, parents and carers of children aged 0-15 scored the trust 8.9 out of 10 ('about the same as other trusts') for the question 'How clean do you think the hospital room or ward was that your child was in?'.
- We were provided with the cleaning audits for July 2015 for both units as well as the paediatric outpatient department and the October 2015 audit for the paediatric unit. A small number of issues were identified and actions recorded with agreed deadlines.

- Each unit was required to provide monthly returns on specific elements of infection control, for example, compliance with hand hygiene, flushing, insertion and monitoring of peripheral venous cannulas (PVC) and central venous catheters (CVC).
- Data provided by the neonatal and paediatric units for April to July 2015 showed that Meadowbank achieved between 98 and 100% hand hygiene, this fluctuated on the paediatric unit from between 88 and 98%. Flushing returns had been submitted weekly for the neonatal unit, apart from one week in April 2015. The flushing returns had not been submitted weekly for paediatrics, one week had been submitted for April, two for May, and three weeks had been completed in June and July, so compliance improvements had been made.
- Neonates had achieved 100% compliance with infection control standards for insertion and monitoring of CVCs and mostly 100% for PVCs, apart from April 2015, where 90% was achieved for ongoing care. For paediatrics data on insertion and ongoing care for CVCs and insertion of PVCs was not provided. PVC ongoing care was reportedly 70% compliant in April, 90% in May, June and July, with 100% compliance in August.
- Compliance with cleaning audits were 96% and 92% in July 2015 for neonates and paediatrics respectively. Data had not been gathered for other months.

Environment and equipment

- The design and layout of the paediatric unit meant that patients could not easily be observed. The clinical assessment unit (CAU) on the paediatric unit had a total of nine beds which could be observed by the nurse and family care assistant working on the bay. The remainder of the unit was spread out along a corridor with the day surgery bay and surgical bay at opposite ends of the unit with 12 side rooms along the corridor. This meant that patients could not easily be observed as there were two or three nurses allocated to these areas depending on the shift time.
- The unit did not have a separate room for Child and Adolescent Mental Health Service (CAMHS) patients. CAMHS patients were cared for either in the CAU or in a side room depending on their assessed level of dependency. When CAMHS patients were admitted to a side room, we were told that any items patients could potentially use to self-harm were removed. However, rooms were not purpose built or ligature free and there was no risk assessment in place for this.
- The resuscitation equipment contained varied sizes of apparatus to cater for the range in ages and sizes of the children. All items were in date and a member of staff had undertaken checks daily throughout December 2015 to ensure all required equipment was in place and in date. However, we noted that there were some gaps in checks performed on the paediatric unit during October 2015.
- We observed that a small number of equipment items had not been PAT tested annually both on the paediatric unit as well as the neonatal unit.
- There was one unlocked treatment room in the paediatric ward. The room contained sharp items which could be accessed by children or teenagers. We requested this be addressed immediately and a keypad lock was fitted on the treatment rooms the next day.
- In the 2014 CQC Children and Young People's Survey, parents and carers of children aged 0-15 scored the trust 8.3 out of 10 ('about the same as other trusts') for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?'.
- The trust had security guards who could be contacted in an emergency or to 'diffuse' a situation. However, nursing and medical staff had not received training in restraint or supportive holding and there was no trust policy. There was a trustwide policy on Violence and Aggression, but this contained minimal reference to restraint and supportive holding and did not take into account relevant guidance, for example, RCN guidance on supportive holding. If an incident occurred which required an immediate response, prior to the arrival of security, staff working on the units may not have the required skills to manage the situation.

Medicines

- Medicines were securely stored in both the paediatric and neonatal units.
- We noted that on both units some liquid medication which had been opened and was past it's 'use by date' remained in the cupboard and available for use. We raised this with the trust who took immediate action. All out of date medication and consumables were removed from the ward on the day we raised the concern and we were told that additional daily checks were being undertaken by nursing staff as well as weekly checks by the ward pharmacist to ensure all medication stored on the unit was in date and clearly labelled.

- Controlled drugs were stored appropriate and administration of controlled drugs was recorded in a separate register as well as in the patient's notes. However, we observed on both units that where a full ampule had not been administered, the amount disposed of was not recorded. This meant there was potential for this to remain unaccounted for.
- The daily stock check required by the trust's policy was not always recorded and we found a discrepancy in the records which had not been identified by the ward staff.
- A medicine administration record specific for children was used and we saw that this was completed appropriately for all patients. However, we noted that some patients had not received their medication within the specified timeframe.
- We saw controlled drugs were stored appropriately. However the daily stock check required by the trust's policy was not always recorded and we found a discrepancy in the records which had not been identified by the ward staff.
- We observed a number of discharge medicines stored on the paediatric unit, including antibiotics, belonging to patients who had gone home in some cases several weeks earlier. Nursing staff told us that there was sometimes a delay in prescribing and dispensing the medicines and patients did not always want to wait for them. Pharmacy staff told us that they had recently introduced a procedure to investigate instances where children went home without their prescribed medicines, to make sure that important medicines were not missed, but this procedure had not been fully implanted as the ward staff we spoke to were unaware of it.
- There had been a number of medicine related errors in the unit over the last year and we saw that the pharmacy team had provided additional training to support the nursing staff in reducing errors. However, errors continued to be reported.

Records

- We observed that all patient notes were stored securely in lockable trolleys.
- We reviewed a sample of patient notes and found that records for patients on neonates were well documented and contained all the required information. Most of the patient records on the paediatric ward contained a good level of detail. Admissions sheets often lacked detail, for example, whether the patient had a social worker and / or health visitor, their weight, parental and contact details were not always recorded. One set of notes reviewed was not in chronological order and some entries had been recorded in retrospect, but the time care was actually provided had not been recorded. One set of notes lacked detail about the care plan for the child, for example, the child had been assessed as 'high dependency' according to the nursing handover sheet, but their dependency level had not been recorded in their notes.
- We were provided with the patient record audit for the paediatric ward for October 2015. The audit considered completion of records for patient care plans, discharge summaries as well as demographics and medication. The audit identified 100% compliance for three of the six audit criteria and between 90 and 92% for review of care plans every shift, demographics and administering medication as prescribed. We were not provided with a completed audit for neonates.

Safeguarding

- 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. The government republished its multiagency practice guidance in 2014.
- The trust's safeguarding policy also included a flowchart as an appendix which outlined the information sharing and referral process. We found that the flowchart lacked clarity on when a referral should be made.
- When a child was admitted to either unit or attended the CAU, a check was made on the system to confirm whether there was an 'alert' on their electronic record, which would indicate that patients were 'known' to social services. Parents on the paediatric unit were also asked whether their child had a social worker. If the child was known to social services or had a social worker, the admitting nurse contacted the social work team to advise of the patient's attendance to the unit. If the child was unknown to social services but staff had concerns, they completed an 'information sharing' form

which was sent to the units internal safeguarding team who then decided the course of action and made a referral or assisted the member of staff in making a referral if appropriate to do so. The team worked Monday to Friday during office hours. Outside of these hours a nurse or member of the medical team contacted social services directly and made a referral if required.

- The neonatal unit followed the same principals. However, we were told that in most cases any safeguarding concerns would have been identified during the mother's pregnancy and therefore a protection plan would already be in place.
- The staff we spoke with all had a good understanding of how to recognise safeguarding concerns and confidently talked about example scenarios as well as the reporting process and that they would always seek advice from the safeguarding team.
- We reviewed the notes of five patients that 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 regardless. 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.
- The neonatal unit and paediatric unit was meeting its target for 90% of staff completing safeguarding training to the required level, for nursing, administrative and 'other' staff. Training data for medical staff was requested but not provided.
- Children attended some of the adult outpatient clinics on a daily basis. Staff working with children and young people should have appropriate training in safeguarding children. Level 3 training is for clinical staff that have key roles in assessing and treating children and young people. In the ear, nose and throat department, only two of the eight nursing staff and none of the 15 audiologists had level 3 children's safeguarding training. As children attended daily, it was not possible to ensure adequately trained staff were on duty when a child attended. In the diabetes clinic none of the clinic staff had level 3 safeguarding training. Children over the age of eight attended the phlebotomy department, but none of the staff had received level 3 safeguarding training.
- In the CQC Children and Young People's Survey 2014, this trust performed 'about the same as other trusts' for questions relating to safeguarding and feeling safe in the hospital.

Patient Safety Thermometer

- As required, the hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from the paediatric ward as well as the neonatal unit. It covered hospital-acquired (new) pressure ulcers, including only the two more serious categories, grade three and four; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). There were no category 2, 3 or 4 pressure ulcers, three falls with harm and no catheter-associated urinary tract infections detected through the NHS Safety Thermometer between July 2014 and July 2015.

Mandatory training

- There were 10 mandatory training modules which each member of staff was required to complete in line with agreed frequency, this included; equality and diversity; fire; health and safety; information governance; infection control; manual handling; NHS conflict resolution; resuscitation level 2 adults; level 1 safeguarding adults and level 1 safeguarding children.
- We were provided with evidence of the percentage of staff that had completed training at service group level for women's and children division. Paediatric and neonatal staff were included in these percentages but a separate breakdown was not provided. The trust had a target of 90% of staff completing the relevant training, this had been achieved for infection control and safeguarding children level 1 but was below the target for all other mandatory training at 83%.
- According to the RCN, '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 RCN guidance.

- The trust provided a list of staff that had completed Intermediate Paediatric Life Support (IPLS) training. Review of the November 2015 rotas indicated there was one shift where there were no nursing staff working who had completed their IPLS; although there was medical cover. 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 and they informed us that one of these shifts did have an IPLS trained nurse on shift but that the rota contained an administrative error. 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.
- We were provided with evidence that 85% of neonatal nurses had completed their neonatal life support training which was below the trust's target of 90%.

Assessing and responding to patient risk

- The paediatric unit had one side room which we were told by nursing staff on the ward was used to care for up to two high dependency unit (HDU) patients. It was subsequently confirmed by the executive team that the room was not used for level 2 HDU patients or were commissioned for this use, but were used for patients who may have, 'higher' dependency needs. Through review of staffing related incidents, we noted staff also referred to having HDU patients on the unit. Staff working on the unit were unclear on the level of patients who should be cared for and therefore there was a risk that they may care for patients who should be transferred to an external specialist unit.
- The neonatal unit was commissioned to provide one intensive care unit (ITU) cot (for short periods until the patient could be stabilised and transferred) and two HDU cots. There were arrangements in place for children and newborn babies to be transferred to other specialist units if they required higher levels of care.
- A paediatric early warning score (PEWS) tool was used to assess, monitor and manage deteriorating patients on the children's ward. A specific tool was used according to the child's age and we saw examples of these completed with scores accurately calculated. Tools had been completed as required for most patients. However, from review of patient files, we noted that there were significant delays in completing the observations for two of the patients. For example, one patient required hourly observations, there were significant gaps in recording the observations and on one occasion, observations had not been undertaken for five hours.
- The neonatal unit used an adjusted early warning tool to assess, monitor and manage deteriorating patients. These had been completed in line with the agreed timeframes.
- The trust audited PEWS documents for paediatrics and the equivalent for neonates. The audit considered whether observations had been recorded on admission, the required frequency had been documented, whether the PEWSs had been added correctly and documented on admission, as well as whether the outreach team had been informed if the PEWS was above an agreed threshold. It was noted that the audit did not consider whether observations had been completed in accordance with agreed timeframes. The September 2015 audit identified that the frequency of observations required was not documented and that the outreach team had not been contacted for 8% of paediatric patients. Findings from the neonates audit indicated high scores had not been escalated for 10% of babies. We requested an action plan from the trust and were provided with a statement to confirm that the paediatric unit had recently been accepted on the S.A.F.E programme (Safe Awareness for Everyone, Royal College and Paediatrics and Child Health) which includes regular safety huddles to include PEWS. And that a theme of the week had recently been introduced which included an audit by the matron and this included PEWS. We were also told that a checklist had been devised to ensure PEWS were checked at each handover so that each patient had a current and accurate score. An action plan for the neonatal unit was not provided.
- Children who were admitted because of mental health reasons were admitted to a side room or were observed on the assessment unit. An initial assessment was undertaken to determine whether the patient required one to one care from a mental health nurse. The department did not employ mental health nurses directly and they were sourced from a local agency. We were told that a mental health nurse was requested and usually arrived within a reasonable timeframe. However, whilst waiting for the nurse to arrive, parents were

requested to observe their child until the mental health nurse reported for duty and we saw evidence of this in the patient notes as well as reported incidents. Such arrangements were not legal as it was the trusts responsibility to care for all patients admitted to the ward. There was an increased risk that patients did not receive the required level of care and may pose a risk to themselves and others.

- The dependency of patients was recorded on the handover sheets. Patients could be assessed as having a dependency of between 1 and 5. With an assessment of 4/5 indicating that the patient required 1:1 or 1:2 care. From review of handover sheets, we saw that the dependency of patients had not been recorded for most patients. Where the dependency levels had been recorded, the level of care provided did not always meet the expected standard. For example, one patient had been assessed as having a dependency level 4 according to the handover sheet, but this was not recorded in their care plan and review of their nursing and medical notes confirmed there was no evidence that they were receiving 1:1 or 1:2 care from nursing staff. This was also confirmed by staff we spoke with, who told us that this patient required 1:1 care but that this was not provided due to lack of staff on the ward. We highlighted this with the trust and were told that an additional family care assistant was employed to ensure the child's needs were met.

Nursing staffing

- The RCN recommends that nursing cover is arranged according to the child's age and the acuity of the patient with a ratio of 1:3 nurses to patients for children under the age of two years and 1:4 for older children.
- The trust had undertaken a staffing needs analysis in July 2015 which concluded, based on activity levels that five qualified nurses were required during the day, three at night and three at weekends on the paediatric unit, with an additional nurse for outpatients and a specialist nurse for ambulatory care. The review did not consider the 2013 RCN guidance. The trust assured us that another staffing needs analysis was due for completion at the end of January 2016 that would take into consideration the RCN guidance, including staffing skill mix.
- Some of the staff we spoke with told us that the paediatric unit was not always adequately staffed. Staff said the agreed minimum numbers of nurses were not always present and that even when minimum numbers of staff were on shift, this was not always enough, depending on the number of patients and their acuity levels.
- We were told by management that during office hours, if the unit became busy, specialist nurses would be requested to cancel their appointments and help the ward staff or if they were not available, managers with a nursing qualification would support the unit. Nursing staff who worked on the ward had mixed perceptions about the frequency with which this happened.
- We reviewed the nursing rotas and handover shifts for a sample of shifts over a two week period during November and December 2015, this included night and weekend shifts. We found that 21% of shifts (all night shifts) were short by one member of staff according to the trust's own minimum standards. We found that 93% of shifts reviewed failed to meet the RCN guidance. This meant that there was a risk that there were not enough staff to meet patient needs.
- We raised our concerns about staffing arrangements and investigation of staffing incidents with the trust. The trust listened to our concerns and took prompt action to ensure the unit was adequately staffed according to the number of patients on the unit. We were also provided with an update on lessons learned from staffing incidents and these made reference to the RCN guidance.
- We were told by management that during the day, Monday to Friday and at weekends, there was always a band 7 nurse working the shift; and there was always at least one band 6 in charge of the shift. However, the nursing rotas showed that there was not always a band 6 nurse on duty and that some shifts were only staffed by band 5 nurses and / or agency nurses. This meant there was not always the appropriate staffing skill mix on each shift in accordance with the trust's own standards as well as RCN guidance.
- We raised our concerns with the trust who informed us that the band 5 nurses who were left in charge were senior band 5 nurses, however, there was no risk assessment in place for this and this did not comply with their own internal arrangements.
- An acuity tool was used to determine whether additional nurses were required. We were told that the acuity of each patient was recorded on the nursing handover sheets. Handovers took place at 7:30am and 7:30pm for each unit.

- The nursing handover records showed that the acuity of patients had not been assessed and recorded for most of the patients. This meant that the required level of nurses on shift could not be accurately calculated and monitored.
- The staff we spoke with told us that they did not always report staffing incidents because they did not have time. A total of seven incidents were reported between the end of September and the end of October 2015, relating to staffing shortages and lack of capacity on the unit. We noted that the escalation policy was not always followed in these instances. For example, one shift reported, that there were '26 patients being cared for by two nurses, a specialist nurse also worked the shift but was providing 1:1 care for a patient. Another agency nurse had been booked but did not arrive. The shift included five HDU patients', even though the unit only had capacity for a maximum of two patients with higher dependency needs. This was reported to the bed manager and agreed no further patients would be taken onto the unit. Additional support staff were sourced but no additional registered nurses. The lessons learned from this were for the organisation that books agency nurses to ensure emails were checked daily. There was no recognition that the unit was not compliant with RCN safer staffing guidance or how nurses could be sourced at short notice should such an incident occur again. The unit had not been reported as not taking any further patients during this period.
- We saw through review of patient files, that staffing levels impacted on patients because medication was not administered on time and observations were not always recorded.
- The neonatal unit was staffed with four nurses on each shift, two of which were qualified in speciality. The British Association of Perinatal Medicine (BAPM) guidelines recommend 80% of nurses working on a neonatal unit are qualified in speciality for a unit of this size. The trust reported they were achieving 77% with an additional nurse in training.
- The staff we spoke with on the neonatal unit told us that most of the shifts were covered with the minimum number of nurses, but there were occasions when they were short staffed, and cover was arranged promptly to ensure the unit was safely staffed. None of the staff we spoke with raised concerns about staffing levels with us and the unit was visibly calm and well managed during our inspection.
- The staff we spoke with told us that they could be understaffed at times and that even when they were fully staffed the ward could be very demanding depending on the acuity of patients. They also told us that all staff worked together to ensure patients were cared for safely. It was the perception of staff that care provided was safe.
- The vacancy rate for nursing staff in paediatrics was 0.1% and 1.7% for neonates in November 2015. The sickness rate was 3% for paediatric and neonatal nursing staff.

Medical staffing

- In 2013 the service was temporarily suspended due to concerns regarding the supervision and training for medical trainees. The service reopened in 2014 and there had been a phased return of trainees agreed by the General Medical Council (GMC).
- A staffing needs analysis had not been completed for medical staff. There were nine consultants employed for children and young people services which provided a whole time equivalent (WTE) of 8.1. An additional 1 WTE consultant had been agreed, to bring the service to 9.1 WTE. The Royal College of Paediatrics and Child Health (RCPCH) recommend in their 'Facing the Future' guidelines that there should be 10 WTE consultants. Though it was the perception of the staff we spoke with that consultant cover worked well and cover was adequate to meet the needs of the units.
- There were seven middle grade doctors with one post currently unfilled and eight junior doctors
- There was a 5.4% vacancy rate for medical staff in November 2015 with 2.2% sickness reported.
- Consultant cover was provided seven days per week from 9am until 9:30pm with an on-call service provided out of hours.
- There was a 'consultant of the week' who provided seven day cover to ensure consistency of care and support.
- Handovers took place twice each day and we observed this happening and found it to be effective, each patient was discussed and relevant information shared with the oncoming team.

Major incident awareness and training

- The trust had a major incident plan reviewed in April 2015 which was due for review in April 2017 and had considered NHS Core Standards for Emergency Planning

(2014). The plan included a section for paediatrics as well as action cards which gave written instructions for key staff who would be involved in the organisation and management in the event of a major incident.

Are services for children and young people effective?

Requires improvement

Services for children and young people required improvement to be effective.

A clinical audit plan had been developed for 2014/15 and 2015/16. However a significant proportion of the 2014/15 audits had not been completed, agreed actions and recommendations did not always address the issues identified.

Policies and care pathways relating to paediatrics and neonates were up to date and had considered national guidance as appropriate.

Pain assessments tools for babies and children were available but were not always completed.

Nutrition arrangements were suitable and patients were offered a choice of food in accordance with their dietary requirements and / or religious preferences as necessary.

The service used a dashboard to monitor performance, although this was difficult to read 'at a glance' and not all relevant data had been included, raw data for some outcomes were provided.

There were arrangements for referring patients to mental health colleagues, although these did not always work quickly and efficiently.

Multidisciplinary arrangements worked well to ensure patients' needs were met and we saw that consent to treatment was gained from patients or their parents.

There was a revalidation process in place to ensure all medical and nursing staff had up to date registration with the relevant professional body.

Appraisal arrangements were in place, although the appraisal rate was below the trusts target of 90% for both medical and nursing staff.

Most nurses who worked on the neonatal unit had a post registration qualification in neonatal care, though the unit was just under the required minimum of 80%, at 77%.

Evidence-based care and treatment

- There were a range of child health policies available to staff on the intranet. There was a structure programme of review. We reviewed a sample of guidelines and found that they were all in date and made reference to relevant national guidelines, including National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecology.
- Staff on the neonatal unit were part of the East of England Perinatal Network. The group agreed guidelines for shared working, developed audit tools to assist consistency of approach, and provided continual improvement of services. This showed participation in local groups and sharing of knowledge and learning.
- Children's health services clinical audit plans for 2014/15 and 2015/16 were based on audits required nationally, as well as to assess compliance with NICE guidance and local priorities identified through complaints and incidents.
- The audit plan listed 27 audits for 2014/15, of which 12 had been completed. The remaining 15 had no reported status or had been deferred for 2015/16. Some included a comment that they were due for presentation in early 2015, but an update on progress was not recorded.
- The 2015/16 plan listed 26 audits. The plan did not record the proposed start or completion dates and three did not have an identified lead responsible for delivery. This meant there was lack of audit oversight across the trust.
- We reviewed a sample of recent audits and found that the audits had clear aims, objectives and findings were detailed. Action plans were recorded. However, these did not always address the issues identified in the audit and timescales for actions to be completed by were unclear. For example, the antimicrobial audit presented in November 2015 listed four key aims which were to ensure, the patient's allergy status was documented on their drug chart, the intended duration of treatment/ review date was documented; the indication for antimicrobial was documented and that there was conformity to paediatric antimicrobial guidelines. The audit identified that 7% of patients did not have their allergy status recorded and patients had been

prescribed and administered antibiotics, that 15% of patients did not have the indication recorded and that 74% of patients were prescribed antibiotics which conformed to the paediatric antimicrobial guidelines. The intended duration of treatment/ review date had not been recorded for 82% of patients. The action plan listed two points, further staff education and review of the paediatric drug chart to prompt recording of review/ stop date and possible indication. The action plan did not state how, when or what staff would be educated about. Issues identified regarding the poor documentation and failure to conform to paediatric guidelines was not included in the action plan.

- We requested evidence of meeting minutes where the audits had been presented. Minutes were provided for one of the four audits requested. Minutes recorded a summary of the audit findings as well as learning points and actions, although the learning points differed to the recorded actions.

Pain relief

- Pain assessment charts were used by staff to help determine pain scores for babies and young children. Through review of patient notes we saw that pain assessments were not completed consistently. Pain relief was prescribed and administered as appropriate when pain assessments had been completed.
- Distraction techniques were used to distract children from painful procedures and anaesthetic cream was used when taking blood from children.

Nutrition and hydration

- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs.
- Food and fluid charts were used if there were concerns about a patient's nutrition or hydration and these were monitored appropriately and used effectively.
- The patients and parents we spoke with told us they were satisfied with the food and hydration provided.
- Staff who worked on the neonatal unit promoted breastfeeding without judgement. They offered support and advice and provided equipment to help mothers as much as possible.
- Hot and cold drinks and snacks were available on the children's ward 24–hours-a-day. Snacks included fruit, sandwiches, crisps and cereals. This meant that patients could have food at any time outside of meal times.
- There was a hot meal served twice-a-day, the choices included healthy options as well as more traditional children's foods. The meals were designed to cater for a variety of ages. We observed a meal time and found that patient choice was supported and that children and young people got their preferred meal when they wanted it. Patients on the children's ward told us the food was good and they could choose what they wanted.
- Special diets such as gluten-free and diabetic and multiple faiths were catered for. Staff said they could order specific foods if required and there were no problems obtaining them. This showed a variety of nutritional needs were catered for adequately.
- On both units patients were weighed and their weight assessed for their specific condition.
- Patients had access to speech and language therapists for swallowing assessments, advice and support.
- Parents could make their own food in a designated kitchen so they could eat with their child.

Patient outcomes

- We were provided with a dashboard for paediatrics which focussed on activity data and did not include information on patient outcomes. We were provided with some raw data for readmissions, which listed the number of readmissions.
- The trust results from the 2013/14 National Paediatric Diabetes Audit showed a lower percentage of patients with HbA1c <58mmol/l than the national average. This could indicate that fewer children had well-controlled diabetes, compared to the average for England and that adjusted HbA1c levels were higher than England average. This meant that the trust's patients, on the whole, had worse diabetes control than the average for England.
- From externally sourced data we saw that the trusts readmission rate between February 2014 and January 2015 for non-elective patients less than one year old within two days of discharge was low. This indicated that fewer individuals were re-admitted to hospital than the England average. The rate was similar to England for non-elective one to 17 year olds. It is worth noting that the service closed during part of 2014.
- The multiple admission rate within 12 months for one to 17 year olds with asthma was 19%. This was similar to

the England rate of 17%. We could not make a comparison for patients less than one year old, or for children with diabetes or epilepsy due to low numbers of multiple admissions.

Competent staff

- Staff completed annual appraisals as part of their personal development review. The staff we spoke with told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. Data provided, confirmed that overall 75% of nursing and support staff on the paediatric unit and 90% of nursing and support staff on the neonatal unit had received an appraisal against the trust target of 90%. Data on the percentage of medical staff who had received an appraisal was requested but not provided.
- There was a process in place to ensure all medical and nursing professionals had their registration status checked. The trust provided us with a statement that all staff employed had a valid and up to date registration.
- Staff did not always have additional skills required to meet the needs of patients in their care. For example, staff were not trained in caring for patients with mental health needs. This had not been noted on the directorates risk register.
- Each shift on the neonatal unit had at least one member that had a post registration qualification in neonatal care, 77% of neonatal nurses had completed their post registration qualification against a requirement of 80%. The trust had plans in place for additional members of staff to complete the required training.

Multidisciplinary working

- The staff we spoke with told us that there was good support from other services, including physiotherapy, dietetics and speech and language therapy.
- Nurse specialists in oncology and respiratory medicine, diabetes and epilepsy were employed to provide expert support to patients and parents in the wards.
- Multidisciplinary team (MDT) involvement in care was documented in patient's notes, although we found one example where an MDT meeting had taken place about one child and the outcome of the discussions had not been recorded in the patient's notes.
- Play therapists were available on the ward, Monday to Saturday. Play therapists provided communication between medical and nursing staff, patients and their parents to ensure the patient's needs were catered for during procedures. Play therapists also provided additional support in distraction for younger children whilst undergoing procedures.
- A dedicated pharmacist came to each ward to check supplies and review drug charts for patients on the ward.
- The department did not hold psychosocial meetings to discuss children who had attended the ward for mental health needs and the department did not have support from a psychologist, although one had recently been appointed. This meant that holistic care and review of patients with mental health needs did not take place.

Seven-day services

- Pharmacy support was available each day with out of hours arrangements in place.
- There were arrangements in place for radiology services and out of hours these were provided on an on-call basis.
- Physiotherapy was available on weekdays, as well as out-of-hours, but we were told that the on-call physiotherapist had not completed training in children's care. This meant that if a patient needed specialist physiotherapy support out–of-hours, the on-call physiotherapist did not have the skills to provide this treatment.
- Access to psychiatric services was available Monday to Friday from the local CAMHS. A psychiatric service was unavailable at weekends, therefore if a child with mental health needs was admitted over the weekend, they would need to wait until Monday morning for a comprehensive assessment. Agency nurses were employed to care for patients with mental health needs as required. There could be a short delay in appointing a mental health nurse, during which time care was provided by another member of staff or the child's parent or carer.

Access to information

- Patient records contained good detail, although we noted from review that some patient records were missing information, particularly on their admission sheet. For example whether the child had a social worker or health visitor as well as contact information.
- A copy of the patient's discharge summary was given to the patient as well as sent to the patient's GP within three working days. However, there had been issues

with the timeliness of discharge letters, because a dual system was used to send discharge letters out. This meant that the data available on the time timeliness of discharge letters showed the trust were not meeting the agreed target. We were told by management that this was largely a reporting error and that discharge letters were sent on time, action was being taken to address the data collection. However, the October 2015 quality group meeting minutes for paediatrics and neonates, noted that there was a confirmed backlog of between 20 and 25 letters. This had been identified as a risk on the department's risk register.

Consent

- Staff we spoke with had a good understanding of gaining consent from children and the guidance around this with regard to a child's capacity to consent, including Gillick competency.
- Written consent could be obtained by the child and / or their parents for certain medical and surgical procedures we saw examples of these.

Are services for children and young people caring?

Good

Care provided to patients at Bedford Hospital was good.

Most of patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff listened to them and were compassionate. This was supported by our observations.

We saw that staff demonstrated an appropriate understanding of the needs of children and young people and made sure that that they and their families were involved in decisions about their care.

There were play specialists seven days per week which empowered children and gave them a 'voice' to ensure they were involved in their care.

Compassionate care

- Most of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after. Although one parent told us that they had attended the unit the previous week and their child had not been reviewed regularly by nursing staff and that staff appeared very busy. The parent of another patient told us, "Staff here are friendly and make regular checks; we had a choice of hospitals to go to for our child's surgery but chose Bedford over other options even though we don't live locally".
- We observed staff supporting and treating patients in a kind and caring manner.
- The Friends and Family Test is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family.
- The paediatric unit response rate for the Friends and Family Test fluctuated each month between 9% and 18% during the period April to October 2015. The positive responses also fluctuated with 100% of patients saying they would recommend the service in May, June and August 2015, compared to scores in September and October 2015 at 90.7% and 85.7% respectively.
- The unit had identified themes from comments made in the survey and as a result had purchased new iPads and wall mounted televisions for the patients. The unit reported that they were currently working with estates to improve the play areas.
- The neonatal unit had recently started using the Friends and Family Test but the data provided to us did not include the response rate. A total of 11 responses were received during October 2015, 10 of which reported positively about the care provided.
- In the CQC Children and Young People's Survey 2014, for questions related to caring, the trust scored 'about the same as other trusts' for 24/27 (89%) of questions, 'better than other trusts' for 2/27 (7%) and 'worse than other trusts' for 1/27 (4%).

Understanding and involvement of patients and those close to them

- All of the patients and relatives we spoke with on the ward and in the outpatients department told us that staff had communicated well with them and that they were satisfied with explanations provided about the treatment and care whilst in hospital. Discussions about the child's treatment were communicated to the child and their parents in a way they could understand.
- Patients and parents said they could be involved in their own care and treatment if they wished.
- Parents were included in the escort of young children to and from theatre to reduce the distress to the child.

Services for children and young people

Emotional support

- There was no professional psychologist or counselling care available to provide emotional support for patients or parents. However, a post for a paediatric psychologist had recently been recruited to. Psychological support for patients or families, who may be distressed, was provided by the medical and nursing team, not specially-trained professionals.
- The unit had access to the trustwide chaplaincy arrangements if required.
- Leaflets and contact numbers were available for external agencies who could provide additional support if required.

Are services for children and young people responsive?

Good

Services for children and young people were good for responsiveness.

The department's business plan included good detail around activity and population data.

Access to the neonatal unit worked well most of the time. Activity for paediatrics was much higher than predicted for the year to date and nursing staff told us the unit became very busy and that this was not always well managed. We raised our concerns with the trust who took prompt action.

A 'passport' had been developed to document care and communication needs for patients with a learning disability, although there were no other communication aids on the unit.

Translation services were used as required and worked well when needed. There were no leaflets readily available in other languages, but these could be produced if required.

There were suitable entertainment arrangements to cater for children and teenagers. There was a separate playroom for younger children as well as a room specifically for teenagers.

There were arrangements in place for parents to stay with their child overnight.

There were a small number of complaints received about the service although these were not always responded to in a timely manner and one complaint had been closed before the investigation had been completed.

Referral to treatment time data between December 2014 and November 2015 showed that approximately 11% of patients waited more than 18 weeks for treatment on a non-admitted pathway and less than 1% waited longer than 18 weeks for admission. This indicated that some patients experience delays from referral to treatment in outpatient appointments.

Service planning and delivery to meet the needs of local people

- The trust provided us with paediatric and neonatal plan for 2014-16 as well as an outline presentation for 2016/17. The plans included some good information around activity, as well as a predicted population growth in 0-15 year olds in the local area, likely to increase demand in paediatric services. The plan also recognised the recent increase in activity but did not include actions to cater for the increase.

Access and flow

- Paediatric patients were admitted to the ward either via a planned admission process or through an emergency admission from a direct referral via their GP or through ED.
- Neonates were admitted via maternity as a planned or emergency admission. Babies could be transferred from other hospitals if required or from the community up to 10 days old, although staff told us this did not happen very often.
- We were told that although the department could become busy at times, staff worked together to ensure patients' journey through the department worked well. Some patients with mental health needs could remain in the department longer than planned if they were waiting for a bed in a mental health unit but most patients were discharged back to the community team.
- We raised concerns with the trust about the activity and nurse staffing levels on the paediatric unit, the trust listened to our concerns and took prompt action to address this by ensuring the required number of nurses per patient ratio were on duty.
- Nursing staff who worked on the paediatric ward expressed concern over the number of patients

admitted overnight or at weekends due to self-harm, attempted suicide or suicidal intent. The local CAMHS did not provide a service out of hours which meant patients had to be admitted until a formal mental health assessment had been completed. This had not been included on the directorates risk register.

- The paediatric department monitored the monthly ward activity including length of stay, primary diagnosis, speciality and source of referral.
- A dashboard was in place for paediatrics which included data on outpatient and inpatient activity, we were provided with the October 2015 dashboard. Details on the average length of stay were not provided. However, the dashboard included details of the number of patients staying for set periods of time and the trust were exceeding their target for the year to date.
- The dashboard was not easy to read and required interpretation, it was not colour coded to easily observe whether targets were met.
- Paediatrics had received a higher number of outpatient referrals for the year to date than anticipated, 1208 compared to a target of 1140. The number of first appointments was much lower than anticipated at 1474, compared to a target of 1183. The number of follow-up appointments far exceeded the predicted number for the year to date, 1116 attendances compared to a predicted 693.
- Referral to treatment time data between December 2014 and November 2015 showed that approximately 89% of patients were seen within 18 weeks for treatment on a non-admitted pathway and less than 1% waited longer than 18 weeks for admission. This indicated that some patients experience delays from referral to treatment in outpatient appointments.

Meeting people's individual needs

- The paediatric consultant body had experience in general paediatrics and neonates, and some had their own specialist interests and ran specialist clinics. Consultants had been instrumental in setting up specialist services for patients with diabetes, cystic fibrosis and oncology. There was evidence to reflect how cohesively the paediatric consultant body worked and helped each other.
- A 'patient passport' was completed for patients with learning difficulties to explain their likes and dislikes and how they could be supported and cared for.
- There were no communication aids in place to support patients with learning disabilities, such as a communication book which could have included pictures and diagrams. Reliance was placed on parents and carers to inform staff of the child's likes and dislikes.
- Translation services were available, although we were told that these were rarely needed. Language Line was used and worked sufficiently well and a translator could be booked if required.
- Leaflets were not readily available in other languages. We were told that leaflets could be produced in other languages if requested. However, they were not frequently needed.
- There was a playroom for young children which contained toys and books and a separate room for adolescents with DVDs and books and a computer gaming system in the room for adolescents.
- Parents on the neonatal and paediatric unit had the option to stay overnight with their baby/ child and 'put you up' beds were available. There was also a parents' room available to accommodate parents in a more comfortable setting if required.
- The trust scored 'about the same as other trusts' in the two responsive questions from the CQC Children and Young People's Survey 2014. The score for 'Do you have access to hot drinks facilities in the hospital?' was 8.3 out of 10, and the question 'How would you rate the facilities for parents or carers staying overnight?' scored 7.5.

Learning from complaints and concerns

- Five complaints had been received about the paediatric and neonatal unit between May and November 2015. All of the complaints had been closed, although one complaint had been closed shortly after receipt, even though this had been reported as a serious incident and the investigation was not due for a further three months at the time of closure. The outcome for this case had not been provided. One complaint had been reviewed and closed on a timely basis, three others taken between one and two months to be reviewed and responded to. Lessons learned were documented for each of the complaints which had been upheld.
- Although complaints were received infrequently we were told that they were discussed at staff handovers as and when they occurred. Staff told us there was no mechanism for shared learning from complaints made

in any other part of the organisation. This meant that opportunities to improve practice as a result of investigations into complaints were not shared with the paediatric and neonatal units.

Are services for children and young people well-led?

Requires improvement

Children and young people's services required improvement for well led.

There was a vision for the directorate, although most staff were unaware of what the vision was.

The business plan contained some strong information, although was weak around its direction and we were not provided with evidence of achievement against the plan.

The paediatric and neonatal unit quality group was the main meeting for paediatrics and neonates. Minutes demonstrated some agenda items were discussed in detail whilst other items lacked information or evidence of discussion; actions agreed were carried forward to subsequent meetings, although not all issues led to actions being formulated and agreed where it would have been appropriate to do so.

The risk register failed to consider a number of risks, including some we identified during our inspection, for example staffing arrangements and there not being a ligature free room for CAMHS patients.

Staff felt listened to most of the time by their managers and senior staff, but some staff commented that management failed to respond to issues raised in relation to staffing shortages.

There was a lack of learning from incidents and some of the staff we spoke with were unaware of incidents which they had not reported or been involved with. Incident were not consistently reviewed or investigated on a timely basis.

Staff told us that there were positive working relations between the different staff groups and that they enjoyed working at the hospital. Staff and patients were given the opportunity to provide feedback about the service and we saw examples where patient feedback had been acted on. There was an action plan for staff feedback, but we saw no evidence that action had been taken.

Vision and strategy for this service

- The vision for the women's and children's division was, 'To provide safe, innovative care building integrated services that are informed by the voices of those that use the services and delivered by skilled, compassionate practitioners who are supported by effective systems and processes'. Most of the staff we spoke with did not know what the vision was for the service.
- We requested a copy of the business plan for 2015/16 as well as the plan for the previous year with details of achievement against the plan. The trust provided us with paediatric and neonatal plan for 2014/16 as well as an outline presentation for 2016/17. However, the plans provided did not include details of progress made.
- The plans included key outcomes which were linked to the trust objectives. However, they lacked detail both in the outcome as well as measures to monitor achievement. For example, there was one outcome for paediatrics which was, 'Viable Paediatric Unit', this was supported by seven measures, one of the measures was, 'Sustainable cost effective model of care', a second, 'reputation' and a third was to regain the oncology service. Some of the measures but not all were covered in more detail in a separate section of the plan. The detail included an analysis of strengths and weakness as well as an option appraisal.
- The plan included some good information around activity as well as a predicted population growth in 0-15 year olds in the local area, the plan noted that this would likely increase demand in paediatric services. The plan also recognised the recent increase in activity but did not include actions to cater for the increase.
- The plan did provide an outline of workforce changes required, although these were not assessed against the forecast of an increase in population and demand.
- The plan was not easy to follow and we were not provided with evidence of achievement against the plan as requested.

Governance, risk management and quality measurement

- The paediatric and neonatal unit quality group (PNUQG) monthly meeting was the main meeting attended by staff from both units. The group reported to the quality board and risk and compliance board and received reports from the safeguarding children's group, governance group, risk co-ordinator meetings, paediatric meetings and neonatal meetings.
- The PNUQGs purpose was to ensure high standards of patient care, to monitor performance relating to patient safety, experience and effectiveness, clinical and non-clinical risk, education, shared learning from incidents, audits and complaints, staff and patient feedback as well as other external reviews and data sources.
- The September and October 2015 PNUQG meeting minutes confirmed discussions held were documented and agreed actions carried forward to the next meeting. However, the level of discussion recorded varied, for example, there was good discussion recorded around a serious incident which had occurred, but monthly themes and trends were simply listed without any further discussion. Some incidents repeatedly occurred each month, for example medication errors, yet there was no discussion or agreed action to address this.
- We also noted for example that actions were not agreed for all issues reported. For example, it was reported in the October 2015 minutes that parents visiting on the neonatal unit reported they were unaware of the facilities available to them. This was noted in the minutes, but action was not agreed.
- Reports and updates from sub-committees were presented. At the end of the minutes, a summary of issues requiring escalation were included for escalation to the quality board, which showed good communication and reporting between the groups. It was noted that two of the issues included for escalation had not been recorded as discussed elsewhere in the minutes; therefore it was not possible to see what had led to these concerns. For example, staffing issues with 1:1 care on paediatrics.
- The risk register was included as an agenda item at the PNUQG, potential new risks were presented and existing risks listed in the minutes, with details of their next due review date.
- The December 2015 risk register included six risks for neonates and paediatrics. Risks were red, amber, green rated depending on the level of risk. Two of the risks were rated amber (medium risk) and the others were rated green (lower risk). The risks identified included a description, details of controls in place, date last reviewed and date due for review. The register did not include the date the risk was added to the register, some risks were historic and had been on the register for a number of years. This meant that the PNUQG were unable to monitor the effectiveness of how the risk was managed over time.
- We noted some areas of concern during our inspection which were not included on the risk register. For example, short staffing on the paediatric unit and parents temporarily caring for their child whilst awaiting a registered mental health nurse to arrive.
- The dashboards were not presented or discussed in detail at the group meetings and there was no evidence how activity and performance was monitored and discussed.

Leadership of service

- The clinical management for medical and nursing staff was well established with long serving managers in post. The staff we spoke with reported that they had good relationships with their immediate manager and that they would feel comfortable expressing their views to more senior management if they needed to.
- Some nursing staff told us that although managers were approachable they did not always act on concerns raised, particularly around nursing staff shortages. Most of the staff we spoke with told us that when the unit became busy the matron would help out clinically if necessary.
- We also noted that the risk register had not been used effectively to ensure all significant risks were captured and there was a lack of detail in meeting minutes and actions were not always agreed in response to issues raised.
- Incidents were not always reviewed and investigated on a timely basis and there was no consistent process for shared learning from incidents across the units or hospital wide.
- During our inspection we identified serious concerns with the levels of paediatric nurses working per shift. Although some incidents had been reported these had not been appropriately escalated internally prior to our visit.

Culture within the service

- The staff we spoke with in the paediatric and neonatal units told us that they enjoyed working at the hospital and that there were good working relationships between medical, nursing and support staff.
- We observed positive interactions between all staff groups.
- Nursing staff told us that they felt comfortable in raising issues directly with consultants if they needed to and always felt listened to.

Public engagement

- Patients were given the opportunity to provide feedback as part of the National Children's Survey 2014 as well as via the Friends and Family Test. We saw examples of comments which had been made and acted on by the team, for example, purchasing iPads and televisions.

Staff engagement

- An annual staff survey took place each year to gauge staff perception on a range of matters. We were provided with a copy of the action plan which included five identified weaknesses for the women's and children's division. The agreed deadlines for all actions were September 2015. However progress against the plan had not been recorded. We noted that issues around managers not acting on staff concerns was raised as part of the survey, which was an issue some staff told us about.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.

Innovation, improvement and sustainability

- There were no areas of innovation identified. However, medical staffing arrangements had improved since the General Medical Council had taken action to close the unit and the staff we spoke with told us that they felt well supported and that there were good structures in place for supervision.

End of life care

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

Information about the service

Bedford Hospital provides a range of services to over 270,000 people living predominantly in north and mid Bedfordshire.

Bedford Hospital is a 425-Bed district general hospital. The trust had 24,899 inpatient admissions between 2014 and 2015.

There are no dedicated wards for the provision of end-of-life care at Bedford Hospital. End-of-life care is delivered on most wards in the trust.

There have been 801 deaths in the trust's hospital between July 2014 and June 2015.

In addition, significant numbers of patients were cared for in the trust at some time, during the last year of their life.

The trust told us that the specialist palliative care team (SPCT) had received 501 referrals between April 2014 and March 2015. 382 (76%) had a diagnosis of cancer and 119 (24%) had non-cancer diagnosis. The SPCT has palliative care clinical nurse specialists (CNS) and a palliative care consultant. The SPCT provided palliative care to patients and supported the patients' families. The team also supported other professionals to deliver palliative care.

The trust provides appropriate multi faith facilities, a mortuary and bereavement office.

During our inspection, we spoke with three patients and three relatives. We also spoke with over 20 members of staff, which included; the specialist palliative care team, mortuary staff, chaplain, nursing staff, medical staff, bereavement officers, resuscitation officers and porters. We observed care and treatment and looked at care records and 32 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. We received comments from our listening event and we reviewed the trust's performance data.

End of life care

Summary of findings

Overall, we rated the service as good for safety, responsiveness, caring and well led. We rated effectiveness as requires improvement.

The trust had in place a replacement for the Liverpool Care Pathway (LCP) called Bedford Hospital care of the dying patient, supporting care in the last hours or days of life (C of D). The care plan provided guidance for staff to deliver end of life care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Implementation of the C of D care plan had been slow but the SPCT were monitoring implementation of the C of D care plan and had completed actions to improve implementation across the service.

The SPCT had begun a process to monitor the quality of the service effectively. For example, we saw the SPCT had carried out a retrospective medical case review of all ward deaths for a week in February 2015. The notes were reviewed against the One Chance To Get It Right standards The information from this audit was fed into and monitored at the SPCT meeting, end of life steering group, mortality board and to the hospital management board.

Patients we spoke with were very happy with the care that had been provided to them. Relatives we spoke with were happy with the care that their relatives had received

The trust, supported by the partnership for excellence in palliative support (PEPS) team (commissioned by Bedfordshire Clinical Commissioning Group (CCG) and managed by a local hospice) and the local hospice, planned and delivered services in a way that met the needs of the local population. The discharge planning process was supported by the PEPS team which enabled patients' discharge was arranged appropriately.

Overall, we saw that leadership was good. Local leadership was knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them.

The trust had both an executive director and a non-executive director who provided representation of end of life care at board level.

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.

The trust took part in the National Care of the Dying Adult of Hospitals (NCADH) in 2013 to 2014 and achieved one out of seven of the organisational key performance indicators (KPIs). The trust scored lower than the England average of 9/10 clinical KPIs. The trust did however, score substantially better than the England average for the clinical KPI about the percentage of cases receiving a review of care after death. The trust had an action plan in place to improve some aspects of end of life care.

End of life care

Are end of life care services safe?

Good

We rated end of life care service at Bedford Hospital to be good for safety.

Care records were mostly maintained in line with trust policy.

The staff within the service understood their responsibilities for making sure patients were protected from the risk of harm to protect people from abuse. Staff understood their responsibilities in following safeguarding procedures. Where something went wrong, patients received a timely apology. The service had systems in place to recognise and minimise patient risk and we saw evidence that learning from incidents had been implemented within the service.

Most equipment, for example syringe drivers, were visibly clean, well maintained and fit for purpose. There were mechanisms in place to ensure that equipment was regularly checked.

Daily cleaning checklists in the mortuary area were not always completed routinely and in a timely manner. The trust had no assurance that the mortuary was cleaned routinely and in specified time scales.

.Incidents

- There were no never events or serious incidents reported between August 2014 and July 2015 for end of life care services. (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).
- Staff we spoke with in the SPCT, mortuary and chaplaincy team understood their responsibilities to record safety incidents, concerns and near misses. The staff we spoke with understood how to report them using the trust's electronic reporting system (the system to collect and report incidents).
- 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.
- Staff we spoke with in the SPCT and mortuary were aware of their responsibilities and principles with regard to duty of candour regulation. Staff we spoke with were able to provide examples of when an incident had occurred and how they had informed the patient and their relatives of the incident, made an apology and explained how the trust had responded to the incident.

Safety thermometer

- There were no dedicated wards for the provision of end-of-life care at Bedford Hospital. The trust used the NHS Safety Thermometer information, which was ward specific and did not directly relate to the end of life team. The SPCT did not have a measure of the safety and quality of their service in place.

Cleanliness, infection control and hygiene

- Three patients and three relatives that we spoke with told us that they thought the hospital environment was clean and well maintained.
- The SPCT and mortuary staff wore clean uniforms with arms 'bare below the elbow'. We saw staff wearing the correct personal protection equipment (PPE) such as gloves and aprons as per trust protocol and we observed PPE to be accessible throughout the department.
- Porters we spoke with said that they were aware of the PPE protocol for the mortuary and said they were able to access and dispose of the necessary equipment as required.
- The mortuary area was visibly clean. We saw daily cleaning check lists for the department available for completion by staff as they cleaned each area. On inspection, we saw that these were not always completed routinely and in a timely manner. The trust had no assurance that the areas were cleaned routinely and in specified time scale.
- We saw that there were appropriate safety precautions and reliable systems in place to prevent and protect patients and staff from a healthcare-associated infection. Trust infection control guidelines were available in the mortuary. The trust provided us with

their policy for guidance for post mortem precautions to outline the procedure to follow when dealing with deceased patients who had hepatitis B or C, human immunodeficiency virus (HIV) / acquired immune deficiency syndrome (AIDS), tuberculosis and Creutzfeldt-Jakob disease and require a post mortem. This procedure had been compiled in accordance with the Human Tissue Act 2004.

- We saw guidelines to ensure that when the mortuary viewing room and body store was used at the request of HM Coroner Officers appropriate safety precautions were in place to protect untrained staff.
- The mortuary had sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage.

Environment and equipment

- The mortuary was equipped to store 86 deceased patients, 81 in body storage units (fridges) and five in long-term storage. Staff told us these facilities were sufficient to meet the needs of the hospital and local population. There were 10 spaces suitable for bariatric patients. There were specific storage trolleys and large fridges to accommodate them. The service also had a cold store room, which allowed for storage of a super obese deceased person without the need for moving the patient from their bed.
- The trust did not have a bariatric concealment trolley. Porters told us that deceased bariatric patients were transferred to the mortuary on the hospital bed with an oxygen mask over their face but no cover. Staff we spoke with did not feel this was a dignified practice. Staff told us the trust were in the process of purchasing a suitable alternative. The staff were unsure of the delivery date of this equipment at the time of the inspection. This was not on the service risk register at the time of inspection.
- Equipment was available to meet patient needs such as syringe drivers and pressure relieving equipment.
- The National Patient Safety Agency (NPSA) recommended in 2011 that their preferred syringe drivers should be withdrawn as soon as locally feasible, but before 31 December 2015. The trust had replaced the syringe drivers with a recommended alternative following a comprehensive education programme for all nursing staff. The trust told us only one type of syringe pump was used at the hospital. This ensured continuity of care. Syringe drivers we saw in use had been set up correctly and were used appropriately.
- The trust provided evidence of a robust maintenance schedule and asset list of syringe drivers including next service dates.

Medicines

- The hospital used an electronic prescribing and medication administration record system, which protected patients from avoidable harm.
- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life.
- The medicines for palliative care patients were stocked in the clinic room in each ward area for patients requiring palliative care.
- There had been no medication errors reported specifically for the end of life team between August 2014 and July 2015.
- We saw nurses on Elizabeth ward prepare a syringe driver for a patient. They followed correct checking and preparation procedures to ensure the patients were given the right drug at the right time.
- The National Care of the Dying Audit 2014 showed the trust was in line with the England average for their clinical protocols relating to the prescribing of medication for the five key symptoms (pain, excessive respiratory secretions, breathlessness, nausea and vomiting and agitation) at the end of life.

Records

- Medical records we looked at were stored in lockable cabinets. The cabinets were not always locked when we visited the ward.
- The care records and care plans we looked at had been completed with relevant current and previous clinical information. Patients had three sets of notes, medical notes, nursing notes and care plans. Medical notes that are written in by medics and allied health professionals notes. Nursing notes and medical notes were kept in a locked cabinet. The nursing care plans, which included discharge planning, were kept at the patients' bedside. These notes contained the day-to-day care records and observation notes. The C of D care plans, where applicable were kept here. There was a risk that information could be missed if the same information was not noted in all three documents and that less up to date information could be used to formulate decisions.

End of life care

- The C of D care plans we looked at were complete, legible, and up to date and stored securely in patients' notes.
- We saw staff completed mortuary records following trust protocol, using effective note writing practices that provided an audit trail.
- We reviewed 32 do not attempt cardiopulmonary resuscitation forms (DNACPR) across all ward areas and the emergency department and the corresponding medical notes.
- We saw that the DNACPR forms were stored in paper form in the front of the patients' notes. The forms had a red edging so they were easily identifiable.
- All the forms we reviewed were signed and dated.
- We saw that 30 (94%) were counter signed within 24 hours as per trust protocol.
- One of those forms had been signed within 72 hours. One form was not countersigned. We raised this with the ward manager at the time of inspection who immediately addressed the issue.
- Only one form did not include a summary of why CPR was not in the patient's best interest despite guidance in the trust's policy. We raised this with the ward manager at the time of inspection who immediately addressed the issue.
- The cardiac arrest prevention nurse who fulfilled the resuscitation office role informed us that the trust the process for making changes to the DNACPR document. The trust planned to replace this document early in 2016 with a Treatment Escalation Plan (TEP) where all appropriate treatment options for the patient were laid out. The TEP is a form that the doctor completes, ideally with the competent patient or close relative, documenting what treatment options would be appropriate if that patient were to become acutely unwell. The document prompts discussion about ventilation of the lungs, cardiac resuscitation, renal replacement therapy, intravenous fluids and antibiotics.

Safeguarding

- 100% of the SPCT team had received safeguarding children level one and two training and 78% of SPCT were up to date with safeguarding adults training. All staff we spoke with were aware of their responsibilities with regard to reporting safeguarding concerns. Staff we spoke with were able to tell the inspection team what signs of abuse were, and how to locate the trust policy. They knew how to report concerns and who to contact out of hours if they had an urgent concern.
- There had been no reported safeguarding concerns relating to end of life care between August 2014 and July 2015.
- All hospital staff had to undertake safeguarding children and adult training. The level of training required was determined by the role.

Mandatory training

- 76% SPCT staff met the trust's target for staff having had mandatory training. Which was below the trust target of 90%.
- The trust told us that they had poor mandatory training and appraisal rates. The mandatory training rates were at a trust wide average of 72%, which was below the trust target of 90%.
- All staff in the trust were required to attend mandatory training, which included moving and handling, infection prevention, information governance, general health and safety, fire, equality and diversity and end of life care. Staff told us that mandatory training generally met their needs.
- The trust provided education for staff on the care of dying patients as part of mandatory training following the recommendation in its response to the National Care of the Dying Adult of Hospitals (NCADH) in 2013 to 2014.

Assessing and responding to patient risk

- We saw that the trust used the National Early Warning Score assessment tool for recording the observations of patients admitted to the hospital. This tool scores each aspect of patient's observations in order to prompt staff to follow clear procedures documented on the form. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care.
- The wards used an hourly intentional rounding system (Intentional rounding is a structured process where nurses on wards in acute hospitals carry out regular checks with individual patients at set intervals, typically hourly. During these checks, staff carried out scheduled or required tasks.
- Staff told us that patients requiring end of life care were identified at ward rounds or as part of the three times

daily 'quality round'. (The quality round, led by the matron was where the team came together to review a patient's condition and develop a coordinated plan of care). Once identified, the ward team would refer the patient for specialist care.

- Not all patients identified as requiring end of life care were referred to SPCT. The SPCT operational policy provided guidance on the referral criteria. It stated referrals were to be made to the SPCT for patients with one or more of the following:
  - Pain related to progressive disease uncontrolled by simple analgesia; Other physical symptoms uncontrolled by first line management
  - Any severe, related symptoms uncontrolled within 48 hours of starting treatment for it
  - Psychosocial distress in patient or family
  - Need for support/opinion on decisions regarding withholding or withdrawing clinically assisted nutrition and hydration (CANH)
  - Dying complicated by physical symptoms, psychological, social or spiritual distress in patient or family
  - Complex symptoms requiring further assessment on discharge/ specialist support at home.
- SPCT had a triage and prioritising system for their referrals. Staff made referrals via email, phone call or directly to the SPCT when they visited the wards or attended ward rounds. Once the referral had been received, the SPCT completed a form with a 'rag' rating to highlight patients' needs, prioritise the response required and frequency of review. (A rag rating is a visual cue using red amber green rating system or traffic light rating system).
- The trust report that 100% of patients referred to the palliative care team were seen within 24 hours between August and October 2015.
- The SPCT met each morning to discuss their caseload and any new referrals. They used this meeting to discuss diagnostic challenges, management options and any other pertinent issues relating to their current patients can be discussed collectively in this meeting, after which the caseload was allocated appropriately between all available team members.
- Whilst taking a share of the caseload, the palliative medicine consultant was viewed as a medical educational resource for the whole team and an appropriate person to review patients with particularly complex palliative care issues. The SPCT operational policy provided guidance for patients who did not meet the SPCT criteria. Patients who wished and were medically able to be discharged were referred to continuing healthcare rapid discharge service or the PEPS service.
- We saw that risk assessments were in patients notes relating to moving and handling, risk of falls, pain control and tissue viability. We saw that actions were documented to take place where risks were identified, for example, an air mattress requested for a person at risk of tissue breakdown.

Nursing staffing

- SPCT told us that they were at full establishment at the time of inspection. There were 3.8 whole time equivalent (WTE) clinical nurse specialists (CNS) (band 7). There was a full time practice development nurse (band 8a) and a part time administration (0.5 WTE).
- The PEPs also had an in-reach team comprising two part time CNSs based at Bedford Monday to Friday 8am until 4pm to support the transition home from hospital.
- The SPCT working hours were Monday to Friday, 8am to 6pm, Saturday and bank holidays 8.30am to 3.30pm. On Sunday and out of hours, advice was available from PEPS.

Medical staffing

- Medical staffing met that recommended in the National Institute of Clinical Excellence (NICE) guidelines. Commissioning Guidance for Palliative Care published collaboratively with the Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK recommends 1.0 WTE consultant per 850 acute beds.
- There was one part time (0.8 WTE) consultant in palliative medicine and a part time (0.5WTE) specialty trainee in palliative care medicine.
- There was a consultant presence Monday to Friday, with consultant out of hours advice provided through a regional network accessed through the PEPS service.
- Medical cover was provided by two consultants, each with a work commitment to a local hospice. Between the medical staff, cover was provided on the majority of days either as a medical presence or via telephone contact when working off site.

End of life care

- Consultant review of patients occurred as clinically indicated.

Staffing

- The mortuary manager told us that the mortuary was working at full establishment. The mortuary team comprised one full time mortuary manager, and three full time mortuary technicians who fulfilled the bereavement services staff role.
- Porters transported the deceased from the hospital wards to the mortuary and provided out of hours access to the mortuary.
- The chaplaincy team comprised one full time Church of England chaplain and one part time Roman Catholic chaplain.

Major incident awareness and training

- The evacuation routes in the departments, we visited during the inspection were kept clear. Staff we spoke with were aware of what to do in the event of a fire and had attended mandatory fire training.
- The trust had a major incident plan in place. Mortuary staff spoke with were aware of contingency plans and their role within these. The mortuary manager would attend site on an occasion of a major incident to look at capacity of mortuary storage facilities. The manager told us that the hospital had arrangements with the local council in the event that more capacity was required.
- Out of hours the mortuary staff, and porters' office controlled access to the mortuary.
- Mortuary staff told us that there were alarm systems in place to alert staff in the event of mechanical failure of the fridges. These alarms were routed to main reception who would alert the mortuary manager. On the occasion of an out of hours fridge failure, the on-call mortuary staff would be contacted via the main reception to enable them to contact on-call repair service.

Are end of life care services effective?

Requires improvement

We rated the service as requiring improvement for effectiveness.

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.

The trust took part in the National Care of the Dying Adult of Hospitals (NCADH) in 2013 to 2014 and achieved one out of seven of the organisational key performance indicators (KPIs). The trust scored worse than the England average for 9/10 clinical KPIs. The trust did however score substantially better than the England average for the clinical KPI about the percentage of patients receiving a review of care after death. The trust had an action plan in place to improve some aspects of end of life care.

The service did have local audits in place to measure the effectiveness and outcomes of the service.

The trust had developed a care-planning tool called the care of the dying to replace the Liverpool Care Pathway (LCP). The tool was used across the hospital.

SPCT staff were competent in their roles and supported by some effective processes for ongoing professional development. Most staff had attended appraisals and group supervision.

Evidence-based care and treatment

- Following the removal of the "Liverpool Care Pathway" (LCP) nationally, the trust had developed The Bedford Hospital Care of the Dying patient care plan, supporting care in the last hours or days of life (C of D).
- The C of D care plan had been ratified in June 2014 following consultation with ward staff and community health care professionals. It was in line with the five priorities of care document promoting individualised care and communication. The document stayed with the patient on discharge and used by the community team.
- Education for staff in the use of the C of D care plan was completed in October 2015.
- At the time of our inspection, we saw that the C of D document was in use but SPCT reported that the uptake

had been lower than they had anticipated. The trust was in the process of monitoring its use and had been targeting staff education to address this issue. Staff we spoke with told us that they were aware of a care plan being introduced to replace the LCP. We saw that use of the C of D document had increased from 22% in May 2015 to 75% in November 2015.

- We saw the forms staff used to monitor the use of syringe drivers were used appropriately and in accordance with the recommended guidelines.
- The SPCT had written clinical guidelines for the prescribing of anti-emetic medication for palliative patients. It was noted it had been written using the 4th edition of the palliative formulary. The 4th edition is not the most current edition however there were not any specific changes that made using this edition dangerous.
- We saw that the SPCT operational policy (date of approval: August 2015, review date: August 2018) had been written in line with the NICE Quality standards for end of life care for adults 2011, National Cancer Peer Review Programme NICE Improving Supportive and Palliative Care for Adults with Cancer March 2004 and End of life Care Strategy 2008 One Chance to get it Right 2014
- The mortuary had been licenced by the Human Tissue Authority (HTA) to allow post mortem examinations and storage of bodies. The trust informed us that they renewed the licence annually, following a self-assessment audit
- The mortuary policies were up to date evidence based and relevant for the service they provided.
- Ward staff, mortuary staff and porters were aware of these policies and told us about the procedures they followed and equipment they used.

Pain relief

- There was trust guidance for prescribing palliative medication and guidance for the use of anticipatory medication at end of life, which provided guidance for pain relief. It was called 'Quick List' for anticipatory prescribing. Anticipatory medications refer to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life so that these medicines can be given if required without unnecessary delay.
- The SPCT had carried out an audit of pain relief management and symptom management, including the use of anticipatory medication. We saw that there had been an increase in prescriptions of anticipatory medication from less than half the sample group in May 2015 to 100% in November 2015. It was felt that this provided evidence that staff were assessing patients and prescribing to reduce the impact of symptoms more effectively.
- The three patients we spoke with reported they received their pain relief medication promptly.
- We were unable to look at appropriateness of prescriptions, as we did not have access to the electronic prescribing system.
- Pain relief was included in the hourly intentional rounding check. The ward staff assessed patients' pain using Abbey pain scale.
- Staff told us syringe pumps used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner.
- We saw that there had been a review of prescribing opioids in palliative care planned for September 2015. During our inspection, we did not see any evidence that the review of the guidance or monitoring effectiveness of the invention had taken place. We did not see the results during our inspection.

Nutrition and hydration

- We saw staff assisting patients to eat and drink at lunchtime. Staff sat down with patients to do this. We observed them chatting appropriately making the mealtime relaxed.
- In one set of notes we reviewed there had been a referral to the dietician. The patient told us that the dietician had visited and had advised on what they could eat and drink, staff supported the patient to make suitable menu choices.
- The C of D care plan provided prompts for staff specifically about nutrition and hydration for dying patients. It prompted the staff to assess four hourly that the patient had received food and fluids to support their individual needs. It stated that patients were to be supported to take food and oral/thickened fluids for as long as they were able. It also prompted them to monitor for signs of aspiration and or distress. The care plan prompted staff to explain the plan of care with the patient and relatives. We observed that nutritional

assessments were completed in the four sets of notes we reviewed. The nursing records that we saw, such as nutrition and fluid charts, were thorough and summarised accurately.
- We were made aware of a recent complaint from a family who had reported that there had been no monitoring of nutrition or hydration. This complaint was under investigation.
- The Malnutrition Universal Screening Tool (MUST) was used to identify patients at risk of malnutrition and they were generally well filled in. It included management guidelines to be used to develop a care plan. The tool was used in line with recommendations from the British Dietetic Association (BDA) and Royal College of Nursing (RCN).
- We saw that menus catered for cultural preferences.
- Patients we spoke with were complimentary about the food that was provided.

Patient outcomes

- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) in 2013 to 2014 and achieved one out of seven of the organisational key performance indicators (KPIs) which was clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust did not achieve the following organisational KPIs regarding access to information relating to death and dying:
  - They did not have access to information relating to death and dying,
  - They did not have access to specialist support for care in the last hours or days of life,
  - They did not have continuing education, training and audit,
  - They did not have trust board representation and planning for care of the dying.
  - They did not have clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient.
  - They did not have formal feedback processes regarding bereaved relatives/friends views of care delivery.
- The performance of the service was poor in the clinical case note review part of the audit. The nine clinical KPIs that were not met were:
  - Multi-disciplinary recognition that the patient is dying.
  - Health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying.
  - Communication regarding the patient's plan of care for the dying phase.
  - Assessment of the spiritual needs of the patient and their nominated relatives or friend.
  - Medication prescribed prn for the five key symptoms that may develop during the dying phase. (PRN means pro re nata, which means as it is needed.)
  - A review of interventions during the dying phase.
  - Review of the patient's nutritional requirements.
  - A review of the patient's hydration requirements.
  - A review of the number of assessments undertaken in the patient's last 24 hours of life.
- Out of the 10 clinical KPIs, the trust met one score substantially better than the England average (for the percentage of cases receiving a review of care after death). The remaining KPIs scored worse than the England average.
- The trust had an action plan in place to improve some aspects of end of life care. The trust reported that current practice was substantially different from that audited in the 2013/14 NCDAH. Changes in practice had been prompted by the action plan. The trust had introduced and educated staff in the use of the C of D care plan. There was executive and non-executive representation at board level. The trust routinely audited care provision against the One Chance To Get It Right standards and had introduced a bereavement survey and had introduced a 'Quick List' for anticipatory prescribing. The trust undertook an internal audit of notes of dying patients against the organisational and clinical KPIs used in the 2013/14 NCADH audit. This audit found that the trust had improved its performance against two organisational KPIs and against eight clinical KPIs.
- The action plan was being monitored through the End of Life Steering Group, which was held monthly.
- The trust had submitted information for the NCDAH for 2015. The SPCT were waiting for the results, which were due early in 2016
- We were provided with a copy of the SPCT annual activity report April 2014 to March 2015. It showed that

the team had received 501 referrals between April 2014 and May 2015. 382 of the patients who had been referred had cancer (76%) and 119 (24%) had a non-cancer diagnosis.

- The trust were not part of the Gold Standards Framework accreditation scheme at the time of inspection.
- The SPCT had started to collect information about the outcomes of patients care and treatment. They monitored the level of intervention for example whether the intervention was a professional to professional advice meeting, a one off meeting with the patients to provide advice or more longer term intervention to provide support to the professional and patient from diagnosis until death.
- The SPCT had carried out a retrospective medical case review of all ward deaths for a week in February 2015. The notes were reviewed against the One Chance to Get It Right standards. The team found that they were failing to identify imminently dying patients and as a result were failing to meet the standards of the care set out in the five priorities set out by the One Chance to Get It Right standards. They also found that that where the SPCT were involved the five priorities set out by the One Chance to Get It Right standards were more likely to be met. The team had devised an action plan to improve the care provided. The information from this audit was fed into and monitored at the SPCT meeting, End of life steering group, mortality board and to the hospital management board. We saw that the diagnosis of dying was addressed at teaching sessions held for the emergency department staff and at the nurse champion study days. The SPCT were attending quality rounds and consultants attended MDT meetings on the care of the elderly wards and at COPD MDTs.
- The community SPCT collected information on the percentage of patients who achieved discharge to their preferred place of death. This information was fed back to the SPCT meeting. We were told that 69% of patients known to the SPCT in mid Bedfordshire achieved their preferred place of death between May 2014 and April 2015. The trust used this information, to monitor if the trust was able to honour patients' wishes.
- The service contributed data about end of life care to the National Minimum Data Set. The National Minimum Data Set (MDS) for Specialist Palliative Care Services is collected by National Council for Palliative Care on a yearly basis. The aim of this was to provide an accurate picture of hospice and specialist palliative care service activity. Information collected included numbers of patients using the services, mean length of stay / care, demographic information: sex, age and ethnicity, a breakdown of diagnosis, particularly in the case of conditions other than cancer and contacts between staff and patients / carers.
- We saw the trust carried out routine DNACPR audits. The trust provided us with the data from a DNACPR audit carried out in June and July 2015. The resuscitation team told us that they carried out an audit on medical and surgical wards and they fed back the results to the specialty lead. The resuscitation team had developed an action plan from the most recent documentation audit results. The action plan identified commonly missed information and the specialty with most missed information. The resuscitation team fed back the audit information to each specialty and carried out targeted training sessions when necessary.

Competent staff

- Staff told us that appraisals took place and they were up to date. We were given information by the trust that stated in December 2015 only 56% of the SPCT had up to date appraisals. 75% of the mortuary team were up to date with their appraisals and the chaplaincy team were 50% compliant with appraisals. The resuscitation team were 100% compliant for appraisals.
- The team attended monthly group supervision with a clinical psychologist.
- The SPCT had attended relevant study days and training courses to maintain their competence for example palliative care module degree level, (Oxford advanced pain and symptom control course, and East of England cancer network palliative and end of life care event.
- The palliative care champions attended training sessions approximately five times per year. These sessions assisted in maintaining competency for their palliative care champion role. We saw an agenda for these training days, which included symptom control and management training such as skin care and bowel care. The palliative care champions shared relevant knowledge, processes and skills to their ward teams during team meetings and shared documents through ward newsletter. We saw evidence of feedback from the champions to ward staff in Elizabeth ward team meeting minutes (team meetings were held every two months).

End of life care

- Doctors working in the palliative care services maintained their revalidation working in conjunction with the local hospice.
- The SPCT were responsible for providing end of life care training and embedding the Care of the Dying care plan. The team provided assistance when required to other disciplines and organised standalone courses and study days. We saw that SPCT provided training on the trust induction, training for overseas nurses and on the clinical support worker training.
- Each ward had a palliative care champion who acted as the link with the SPCT. These were band 6 nurses with an interest in palliative care. The SPCT, supported by the PEPS service and local hospice, provided the palliative care champions with training sessions approximately five times per year. These sessions assisted in maintaining competency for their palliative care champion role. We saw an agenda for these training days, which included symptom control and management training such as skin care and bowel care. The palliative care champions shared relevant knowledge, processes and skills to their ward teams during team meetings and shared documents through ward newsletter. We saw evidence of feedback from the champions to ward staff in Elizabeth ward team meeting minutes (team meetings were held every two months).
- Ward staff and the SPCT told us that the SPCT practice development nurse (who had been in post since June 2015) had been working with wards to provide training working alongside the staff providing care role modelling good practice and sharing knowledge.
- Staff from the bereavement office provided training for junior doctors on completion of death certificate of cause of death during their induction to the hospital.
- The mortuary staff were aware of recent developments in anatomical pathology technology. They maintained their awareness of recent developments accessing information through the association of anatomical pathology technology and the Human Tissue Authority website.
- The mortuary team did not have regular formal supervision. The mortuary manager addressed performance issues, concerns, and complaints informally. The mortuary and bereavement office staff appraisal rate was 75%. This did not meet the trust target of 90%.
- There were no specific training courses for the porters to assist them in their role providing out of hours access to the mortuary. The porters trained each other, an experienced porter passed on their skills and knowledge to new portering staff when they accompanied them when completing a task.
- The appraisal rate for the portering team was 72%.
- There was no last offices policy; staff on the wards trained each other on correct practice. No concerns had been raised about the preparation of deceased.
- The resuscitation team provided the basic life support and immediate life support training on site. The team were responsible for the trust's resuscitation policy.
- The appraisal rate for the resuscitation team was 100%, which met the trust target.

Multidisciplinary working

- The SPCT attended a number of other specialties' multidisciplinary meetings such as the lung specialty, upper gastrointestinal specialty and cancer of unknown primary meetings to provide support and guidance
- We spoke to nurses on the wards about their links with the palliative care team. They told us that they were able to refer patients to the team for review promptly, and call the nurses for advice on patient care.
- Feedback for the consultant focus group was that palliative care work in an advisory capacity within the hospital had an excellent relationship with the different specialty teams.
- Feedback from band 7 focus group was that palliative care team attend the ward and ward team took on their guidance. That there was good inter-team working and that communication between senior nurses, nurses and consultants was 'inspiring'.

Seven-day services

- The SPCT service was available Monday to Saturday between 8.00 am and 6.00pm, and bank holidays between 8:30am and 3:30pm.
- Out of hours, telephone advice was available through contact with the Bedfordshire PEPS service. The PEPS service also provided a home from hospital service, prevention of hospital admission service support for patients in a community based crisis and clinical advice for professionals.
- The chaplaincy team provided cover 24 hours a day seven days a week. They were able to provide an on-call service outside their working hours.
- The mortuary service was open from 8am until 4pm Monday to Friday with on an-call service outside these

hours. The mortuary and bereavement staff were available 24 hours, 365 days per year and could be contacted via Switchboard. Viewings were not routinely arranged out of working hours.

- We saw operational procedures for staff to follow when dealing with out of hours viewing and identification of bodies. These procedures outlined the management and use of the mortuary viewing room and body storage out of normal working hours.
- The bereavement office was open 10am until 4pm Monday to Friday. There was not a routine facility for relatives to obtain death certificates out of hours, however, in exceptional circumstances this service could be provided with pre-arrangement with the mortuary manager.

Access to information

- The DNACPR forms were stored at the front of the patients' notes. The forms had red edging, which made them easily identifiable and allowed easy access in an emergency**.**
- There was currently no end of life patient register in the trust. The SPCT had read only access to the community register help by the PEPs team. To maintain continuity the SPCT hand wrote the relevant information in to the patient's notes. There was a risk of duplication or that staff would miss information. As a result there may have been some delay in professionals communicating information about patients at the end of their life with general practitioners (GP's) and community palliative care teams.
- Medical staff told us that they would call consultant for palliative care to discuss plans of care arranged for patients in their care to ensure that messages were understood. They told us that they had an excellent relationship with the consultants for palliative care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not see robust evidence of mental capacity assessments being carried out and recorded. Following the case of Tracey v Addenbrooks that clarified that whilst the decision is to be based on clinical judgement, the information must be given to the patient and/or family where relevant. (The Court of Appeal in a landmark judgment handed down in relation to Janet Tracey (2014) found that an NHS trust had a legal duty to tell a patient, with mental capacity, that a Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) order had been placed on her medical records).
- We reviewed 32 DNACPR forms across all ward areas and the emergency department. In 16 forms, we reviewed, it was stated that the doctor had not informed the patient directly where a clinical decision for a DNACPR had been made. This appeared to be because the patient lacked capacity. However, in these cases, no formal mental capacity assessment had been undertaken of the patient's ability to understand this decision and to participate in any discussions. This meant that staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.
- The trust's DNACPR form did not prompt staff to carry out a formal assessment to establish if the patient had mental capacity to make and communicate decisions about CPR, as recommended by Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2015).
- Most forms stated that the decision about DNACPR had been communicated with a relative if the patient lacked mental capacity and was unable to participate in discussions. 20 (62%) of the notes included a summary of communication about DNACPR with either the patient or their relatives.
- Two sets of notes (7%) did not evidence that the decision about DNACPR had been communicated with the patient, a relative or next of kin or why this had not been done. This is against trust policy which states "Clinicians should document the reason why a patient has not been informed of a DNACPR order if the decision is made not to inform them. Clinicians may be asked to justify their decision." Without a summary of the discussion, there was a risk that staff completing the document would not have evidence of the discussion they had.
- Staff we spoke with demonstrated a good understanding of their responsibilities regarding the MCA and knew what to do when patients were unable to give informed consent. We saw mental capacity assessments for decisions around provision of falls prevention equipment and blood transfusion. However, we did not see mental capacity assessments for the patient's ability to understand a decision regarding DNACPR.

End of life care

- Staff we spoke to understood the Deprivation of Liberty Safeguards and explained the process they would follow if they felt a patient was at risk of harm to themselves or others.

Are end of life care services caring?

Good

We rated end of life services at Bedford Hospital to be good for caring.

Patients we spoke with were very happy with the care that had been provided to them.

Relatives we spoke with were happy with the care that their relatives had received.

We saw staff carry out care to patients in a respectful and careful manner. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.

We saw evidence that patients were involved in making decision about their care. We saw evidence that the staff had spent time talking to patients and their relatives. Patients and those close to them were communicated with and received necessary information in a way that they could understand.

Compassionate care

- The trust had started to hand out a bereavement questionnaire to bereaved relatives on 15 December 2015. The questionnaire was given to the relatives when they attended the bereavement office to collect the death certificate. At the time of the inspection, no questionnaires had been returned.
- We spoke with three patients. They told us that they were happy with the care they had received. They felt that staff had treated them and those close to them with respect and dignity. Patients told us that staff were particularly respectful when they had assisted them with personal care.
- We spoke with three relatives. They told us that they were happy with the care their relatives had received.
- We saw staff carrying out care with a kind, caring, compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.
- We observed staff had positive relationships with patients and those close to them. We saw that staff spent time talking to patients and those close to them.
- SPCT showed us a number letters of thanks. One letter said, "We appreciated everything you did, the care you gave and how you treated her with dignity and respect." Another letter said "glad that she could die quietly with no fuss and that you understood."
- The hospital had a chaplaincy service. Staff we spoke with on the wards told us that they were aware and appreciative of the chaplaincy service. Staff were aware how to refer patients to them. Staff told us that the chaplaincy team were helpful and easy to access.
- We saw a number of letters of thanks addressed to the chaplaincy team for the care they had provided.
- We saw a number of letters of thanks in the mortuary from relatives thanking the mortuary and bereavement team for the assistance and care that they had provided at a very difficult time in their lives.
- We observed that staff handled bodies in a professional and respectful way.
- The mortuary staff and porters told us that they did not have any concerns about the way ward staff cared for patients shortly after death.
- The maternity team and the chaplaincy team held a non-religious remembrance service for those who had lost babies. These were held annually in October to coincide with baby-loss week. Staff told us it was well attended.
- The NCDAH data showed that the trust did not achieve the organisation KPI of a clinical protocol promoting patient privacy, dignity and respect, up to and including after the death of a patient.

Understanding and involvement of patients and those close to them

- The SPCT, chaplaincy team and bereavement team, provided support for patients and those close to them at end of life. Three patients we spoke with stated that the care they received was very good, and that they felt well informed about what was happening.
- Patients we spoke with told us that the staff communicated with them in a way that helped them understand their care, treatment and condition.
- We reviewed the care records of a patient at the end of their life and saw comprehensive documentation by a doctor around a long discussion with the patient's family around the end of life care for the patient.

End of life care

Emotional support

- The trust employed one full time, experienced, health care Church of England chaplain and one part time (half a day per week) Roman Catholic chaplain. The chaplaincy service also had visiting chaplains from the other main Christian, Muslim, Sikh and Quaker faiths. The team also included trained volunteers, known as chaplaincy visitors, who spent time on the wards visiting patients. The team provided an on-call service outside their working hours. The chaplaincy told us that in most situations they could be with the patient within the hour.
- The bereavement office staff told us that they were not trained in counselling or bereavement, and that their role was to signpost people to further services. They returned property to family and carers and liaised with them around the issue of death certificates.
- The chaplaincy service provided a remembrance service annually.
- Whilst it was not routine for bereaved families to be able to view their deceased relative in the mortuary out of hours, the porters were able to support this service in exceptional circumstances with pre-arrangement with the mortuary manager.

Are end of life care services responsive?

Good

We rated end of life services as good for responsiveness.

The trust supported by PEPs team and the local hospice planned and delivered services in a way that met the needs of the local population.

The trust had a policy for the rapid discharge of patients to their preferred place of death. The discharge planning process was supported by the PEPS team which enabled patients' discharge was arranged appropriately. However, the trust did not audit timeliness of discharge.

We saw care planning tools in use on some wards to support patients living with dementia.

Wards had appropriate rooms for sensitive conversations with patients and their families to take place.

Service planning and delivery to meet the needs of local people

- The trust did not directly collect information of the percentage of patients who died in their preferred location. However, this information was collected by the SPCT covering North and Mid Bedfordshire. This information was provided to the hospital team at the specialist palliative care MDT, which met weekly. This information was used to monitor if the team were honouring patients' wishes and if work was needed to improve this. We were told that 69% of people known to the SPCT in mid Bedfordshire died at their preferred place of death between May 2014 and April 2015.
- The trust had implemented a rapid discharge process to support patients to be discharged at an appropriate time and when all necessary care arrangements were in place. This included provision of a two-hour response for dying patients transferring to their normal residence or to a hospice from hospital. We did not see evidence of the two-hour rapid discharge during our inspection. The trust had started to review the rapid discharge/fast tract discharge in July 2015. We were told that the trust had achieved 35 fast track discharges and they were in the process of reviewing this information to assess effectiveness of the service.

Meeting people's individual needs

- The hospital did not provide a designated ward area for those patients requiring end of life care. Care was delivered on all the hospital's wards.
- There was an open visiting policy for patients receiving end of life care.
- Staff told us they tried to allocate side rooms to patients who were receiving end of life care in order to offer quiet and private surroundings for the patient and their families. They also said that often patients at the end of life had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- The staff told us that there were a limited number of family rooms available on the hospital site for overnight accommodation. Wards could provide recliner chairs for relatives who wished to remain at their relatives' bedsides.
- We saw that staff gave patients and those close to them information leaflets. We saw a joint trust and hospice produced leaflet called 'The dying process'. This leaflet contained information about what to expect when

someone is dying such as physical and mental changes. This leaflet also contained contact details for the SPCT. This leaflet was unavailable in any other language than English.

- We saw the 'This is me' document used on the older people care wards to assist with patients living with dementia. 'This is me', is for people with dementia receiving professional care in any setting. It is a practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It encourages health care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person's needs.
- Bedford Hospital had a chaplaincy service. The team provided spiritual and pastoral care and religious support for patients, their relatives and staff across the trust. Patients, relatives and staff could access the chaplaincy service. Patients could refer themselves. Patients usually contacted the service during their regular visits to the wards. Staff also alerted the chaplaincy team if a patient had asked to see them. Staff we spoke with told us that the chaplaincy team was helpful and easy to access.
- There was a multi-faith room on site (faith and belief room). This was a quiet space where people could pray or reflect. There were candles to light for loved ones and prayer cards, which could be taken away as well as a book for people to write their prayer requests in. The multi-faith room was open 24 hours a day and was used by patients, relatives, carers and staff. There were regular services in multi-faith room.
- For patients who wished to take communion the chaplain or an authorised member of the team brought communion to their bedside.
- Maternity had a bereavement team (no dedicated hours) and specialist room. The bereavement team told inspectors that copies of flow charts to develop bereavement paperwork had been requested by two other trusts.
- The bereavement office's main role was to liaise with bereaved families and co-ordinate the issue of the medical certificate so that the death could be registered and the funeral arranged.
- Bedford Hospital had a mortuary and viewing area.
- The mortuary viewing area was clean and bright and was suitably decorated with comfortable chairs.
- Staff told us that if a patient died when the family were not present, the staff ensured that they offered the family the opportunity to come to the ward before the deceased person was moved to the mortuary.
- The trust had a Macmillan Cancer Support information and support centre at the Primrose oncology unit. It was a joint venture with Macmillan Cancer Support, to ensure that people affected by cancer had access to comprehensive, appropriate information and support. The centre was open from 9am to 6pm Monday to Friday. The service offered a drop in service for information and support, health, financial and life management advice. The team at the centre could refer to other healthcare professionals, provide details of local and national support services and organisations, details about complementary therapies and outreach sessions in the community.

Access and flow

- The SPCT had received 501 referrals between April 2014 and March 2015, approximately 42 per month. 382 (76%) had a diagnosis of cancer and 119 (24%) had non-cancer diagnosis.
- Ward staff told us that whenever possible, patients were cared for in side rooms in order to offer quiet and private surroundings for the patient and their families. Use of single rooms for patients at end of life was not always possible as side rooms were prioritised for patients who required isolation. Staff that looked after patients at the end of their lives told us that sometimes side rooms were unavailable and dying patients had to be looked after in bays with other patients.
- Staff told us that discharge to a patient's home usually took 24 to 48 hours, providing care arrangements were in place.
- The SPCT told us that occasionally discharges were delayed due to difficulty in commissioning services, such as available community care packages or transport. Ward staff told us that discharge could be delayed if patient was waiting for a suitable care home.
- Whilst there were no designated beds for end of life care at Bedford Hospital, the staff delivered end of life care in most wards with the support from the SPCT.

End of life care

- Staff told us that the facilities they had for conducting sensitive conversations with family members were suitable. We saw that there were rooms on the wards that would provide a private space for difficult conversations.
- The trust had a rapid discharge service, including provision of a two-hour response for dying patients transferring to their normal residence or to a hospice from hospital.
- Feedback from the band 7 focus group stated that there needed to be more forward planning for discharge in palliative care cases as they thought that they could be more effective. It was their perception that this would help to speed up the discharge process.
- The PEPs service in-reach team although not employed by the trust, support discharge process for patients at end of life.
- The porters told us that they were able to respond to calls made requesting deceased patient transfer promptly. This was usually within 10 to 15 minutes but definitely within one hour and they were able to prioritise accordingly. Ward staff did not have concerns about these response times

Learning from complaints and concerns

- The SPCT and the mortuary team had not received any formal complaints in the last year.
- The mortuary manager and SPCT manager told us how they would deal with complaints, but told us that this rarely happened with palliative care services.
- They told us that managers investigated complaints and incidents from other departments so that an independent view was taken.
- We saw letters and cards of thanks from relatives/carers addressed to the mortuary and the chaplain in their offices. The teams did not record the number of compliments they received.

Are end of life care services well-led?

Good

We found that end of life services were good for well led.

Overall, we saw that leadership was good. Local leadership was knowledgeable about quality issues and priorities. They understood what the challenges were and took action to address them.

The service had local audits in place to measure the effectiveness and outcomes of the service.

There were effective plans in place to address outcomes of audits such as the National Care of the Dying Audit of Hospitals in 2013 to 2014.

The trust had a director and a non-executive director who provided representation of end-of-life care at board level, which is a recommendation of the National Care of the Dying Audit of Hospitals.

End of life care services received sufficient coverage in board meetings, and in other relevant meetings below board level.

A care planning tool to replace the Liverpool Care Pathway had been implemented and the SPCT were working with staff to improve usage.

Vision and strategy for this service

- The SPCT felt their work was a high priority within the trust.
- There was a palliative care strategy group in place that met monthly, chaired by the consultant in palliative medicine. The strategy group had developed an End of Life Care strategy which was ratified in December 2015 and was to be reviewed before 2018. It was to be monitored through the strategy group.
- A SPCT operational policy was in place that set out the aims and objectives of the team. We saw this was reviewed annually.
- We were given a copy of the annual report produced by the SPCT that covered April 2014 to March 2015. The report covered a review of the past years' service delivery, team achievements and discussed the proposed service delivery. This provided the team with an action plan for the coming year
- The SPCT was committed to providing high quality end of life care and had completed surveys and audits to identify where it needed to make improvements. The palliative care team had a clear vision to improve and develop high quality end of life care across all specialisms.

End of life care

- We saw that the trust board had approved the end of life care action plan in response to the service's review of care provided when the service assessed themselves against the one chance to get it right document in September 2015.

Governance, risk management and quality measurement

- The trust had an end of life strategy with action plans which identified priorities to improve care and treatment delivered at the last stages of life. The service was working in a timely way to achieve the actions identified. This document was to be presented to the trust board in December 2015 (after the inspection). At the time of the inspection the risks identified were not identified on the trust's risk register.
- The trust did not directly collect information of the percentage of patients who died in their preferred location. However, this information was collected by the community SPCT covering North and Mid Bedfordshire. This information was provided to the hospital team at the specialist palliative care MDT, which met weekly. This information was used to monitor if the team were honouring patients' wishes and if work was needed to improve this
- The trust did not collect information of the percentage of patients that had achieved discharge to their preferred place within 24 hours. Without this information, the trust was unable to monitor if they were honouring patient's wishes or if they needed to improve this**.**
- The trust had developed a care-planning tool to replace the Liverpool Care Pathway called the Care of Dying care plan, which we saw, was in use across the trust.
- We did not see any evidence of team meetings or supervision within the mortuary team. When this issue was raised with the team, it was established that this was because it was a small team, performance issues, concerns, complaints and general communications were discussed informally.

Leadership of service

- The director of nursing was the board representative for end of life care, there was also a non-executive director lead that provided representation and accountability for end of life care at board level had been in post for one year.
- All staff we spoke with were aware of who their immediate managers were.
- All staff we spoke with were aware of the roles of the senior management team.
- The chaplain, mortuary team and bereavement service told us that they felt supported and listened to by their line management.
- Staff we spoke with told us that there was good leadership of the SPCT. The team was led by the palliative care consultant and the specialist palliative care nurse team leader.
- All of the ward staff we spoke with knew who the leads were for end of life care.

Culture within the service

- The SPCT staff we observed were respectful and maintained patients' dignity, there was a person centred culture. We saw staff responding to patients' wishes.
- Staff we spoke with told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Staff told us Bedford Hospital was a very local hospital and integrated within the community.

Public engagement

- The trust introduced a bereavement questionnaire during the week of our inspection. The bereavement office staff gave the questionnaire to the relatives when they attended the bereavement office to collect the death certificate. This had been introduced in response to the internal audit of the end of life care services against the One Chance to Get It Right standards carried out June 2015. The audit highlighted that the service was unable to assess whether the communication with patients or relatives was 'sensitive'. The survey aimed to provide this information. At the time of the inspection, no questionnaires had been returned.
- The trust carried out surveys for patient and staff satisfaction, although these did not specifically identify end of life care results.
- The SPCT organised a promotion stand within the hospital during the national Dying Matters Week with display boards and leaflets. This was to raise awareness about end of life care to staff, patients and those close to them.
- The cardiac arrest prevention nurse who fulfilled the resuscitation office role informed us of the process for making changes to the DNACPR document. The trust

planned to replace this document in 2016 with a Treatment Escalation Plan (TEP). Discussion about this proposed change was held at the patient forum and patients had been able to be involved in the development of this document.

Staff engagement

- The SPCT held regular formal team meetings where information and learning from safety and quality audits could be shared.
- The trust carried out surveys staff satisfaction, although these did not specifically identify end of life care results.

Innovation, improvement and sustainability

- There was no significant evidence of innovation, improvement and sustainability across the service.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Bedford Hospital NHS Trust provide outpatient and diagnostic imaging services, including medical, surgical and orthopaedic specialities, interventional radiology, and diagnostic computed tomography (CT) scanning, magnetic resonance imaging (MRI), ultrasound and X-ray. There are weekly 'one-stop' clinics for the breast service and urology, which incorporated diagnostic imaging at the point of consultation.

In 2014, there were nearly 300,000 outpatient attendances at the trust. Trauma and orthopaedics was the speciality with the greatest number of attendances in the 12 months up to June 2015.

We visited a range of outpatient clinics and services: radiology departments, general outpatients, fracture, trauma and orthopaedics, cardiology, dermatology, diabetes, retinal screening, haematology, breast clinic, urology, orthodontics and dental surgery, phototherapy, rheumatology, ear nose and throat (ENT), audiology, and phlebotomy. We also visited the appointment bookings and the medical records collection departments.

We observed care and interactions between patients and staff; we spoke with around 35 patients before and after their appointments and read feedback comments from patients. We spoke with staff in many different roles including nurses, doctors, allied health professionals, health care assistants, technicians, administrative staff and managers. We reviewed performance information from and about the trust.

Summary of findings

Overall we rated outpatients and diagnostic imaging services as requires improvement.

Safety concerns were not consistently identified or addressed quickly enough and necessary improvements were not always made when things went wrong. Infection control procedures were not always followed and clinic environments were not all fit for purpose. Staff working in clinics attended by children and young people did not have adequate training in safeguarding children, and staff were not all up to date with mandatory training. There were staffing shortages across clinical and support staff in many outpatient and diagnostic services. Very few services were provided seven days a week.

Medical records were maintained accurately and securely, and there was an effective records tracking and location system. Clinical areas were generally clean and well-organised. Staff used national and professional guidance when carrying out assessment, diagnosis and treatment. Staff had good opportunities for professional development but the outpatients and diagnostic services did not provide all staff with an annual performance appraisal. In some areas this fell well below the trust target of 90%.

Staff treated patients and their relatives with dignity and respect. Patients were given sufficient information to make decisions about their treatment and felt they were well informed. However, services did not always meet

Outpatients and diagnostic imaging

people's needs and the needs of the local population were not fully identified or taken into account. The environment did not meet the needs of people with dementia or a visual impairment. Despite serving a multi-cultural population, outpatient and diagnostic services did not provide patient information in formats other than written English. There was no easily accessible complaints system and staff had a poor understanding of managing complaints. Patient feedback was limited.

Access to services was well managed. Waiting times for appointments met the national standards and patients were able to attend appointments swiftly, through an effective booking system.

Overall staff were positive about working in their teams and felt well supported by managers. However, the leadership, governance and culture did not always support the delivery of high quality assessment and treatment. There was no clear vision or strategy for the services. Governance and risk management systems did not consistently operate effectively and risks were not always managed in a timely way.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Safety concerns were not consistently identified or addressed quickly enough. Some staff were unclear how to use the incident reporting system and necessary improvements were not always made when things went wrong.

Infection control procedures were not always followed and clinic environments were not all fit for purpose.

Medicines were not always managed safely in radiology. Following a serious incident in interventional radiology, effective safety systems were now in place. There were no diagnostic reference levels available in X-ray, and radiographers were unable to tell us where they were kept and clinical guideline was overdue for review in November 2014.

Staff working in clinics attended by children and young people did not have adequate training in safeguarding children, and staff were not all up to date with mandatory training.

There were staffing shortages across clinical and support staff in many outpatient and diagnostic services.

Clinical areas were generally clean and well-organised. Medical records were maintained accurately and securely, and there was an effective records tracking and location system.

Staff recognised and responded to changes in people's health.

Incidents

- While some staff we spoke with were familiar with using the trust's electronic incident reporting system, others were less confident. The trust provided training on incident reporting and use of the Datix system to all staff on appointment to the trust. However, we spoke with one doctor who had been in post for six months and had not reported any incidents and did not know how to. This meant that patient safety incidents might not be reported and followed up to help improve patient care.

Outpatients and diagnostic imaging

- The ionizing radiation (medical exposure) regulations, or IR(ME)R, provide a framework to protect patients and staff from the risks associated with radiation used in healthcare. Radiology errors, including when the wrong dose had been given to a patient or a patient had received the wrong type of diagnostic test, were reported to CQC in line with the regulations. The errors were all low risk and there was a good local incident management approach. The frequency and type of incidents reported by the trust were similar to those reported by other trusts of the same size.
- Between September 2014 and August 2015, the trust reported 241 patient safety incidents in outpatient departments. Three were serious incidents, and one, a wrong site surgery relating to a radiology procedure, was classified as a 'never event.' A never event is a serious, largely preventable incident that should not occur if the nationally available preventative measures have been implemented. Of the other incidents, most were classified as causing no harm to patients, but seven (3%) were classified as causing moderate harm and 39 (16%) as causing minor harm.
- There was inconsistent evidence of learning from incidents to limit the chance of reoccurrence. Of the seven incidents judged to have caused moderate harm, only one had clearly identified steps that would be put in place as a result.
- Many staff told us they received feedback by email on any incident reports they had made, but some told us they would appreciate speedier and more detailed feedback. Staff told us they discussed incidents in team meetings and discussed changes to practice as a result.
- Lessons learned from incidents were not shared across staff teams consistently. We asked for copies of recent 'lessons learned' cascades but the trust did not provide them. A senior sister showed us an example of sharing learning following an incident affecting patient confidentiality. We had just observed a similar incident taking place. The sister explained that although this was in their department, the staff involved were running a clinic from another outpatient department and were not part of their staff team.
- Staff had responded effectively to the never event and there were better processes in place, including a full induction for all new staff, the use of the World Health Organisation (WHO) Five Steps to Safer surgery checklist, and electronic scanning of referrals so that staff could access all referral details before starting a procedure. They had instituted a 'pause and check' process which was a means of ensuring clear communication among team members and avoiding 'wrong-site' or 'wrong-patient' errors.

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.
- All of the staff we asked about the Duty of Candour were well informed about legal requirements and local procedures**.** Staff had access to information through managers and external trainers attending staff meetings, as well as trust briefings on the internal website. Around ten percent of consultants, matrons and managers had received non-mandatory Duty of Candour training. In addition, the trust provided all clinical areas with guidance on meeting the Duty of Candour requirements.

Cleanliness, infection control and hygiene

- The outpatient and diagnostic imaging clinical areas we visited were visibly clean, tidy and well organised. Cleaning schedules were completed and on display. Sharps boxes for the disposal of items such as needles were used properly. Handwashing facilities were available in the treatment rooms. Infrequently used water outlets were flushed weekly to help reduce the risk of Legionella bacteria which can cause a potentially fatal type of pneumonia.
- Radiology staff and most outpatient staff carried out appropriate infection control procedures, including hand washing, using protective gloves and cleaning equipment following use.
- In April 2015 ten departments were audited by a 'patient led assessment of the care environment' (PLACE) team. All areas passed the cleanliness aspect of this assessment. Staff carried out an environment and cleanliness audit of the main outpatient department in September 2015. The score was good at 95% and we found that several issues had been addressed as a result.

Outpatients and diagnostic imaging

- We saw one hand hygiene audit of the main outpatients department from December 2015. This was not completed thoroughly in that the auditor did not record whether some staff were wearing protective gloves or not. It found two out of the eight staff observed did not comply with the 'bare below the elbow' policy, but there was no indication of subsequent actions.
- In phlebotomy, where patients had blood samples taken for testing, we observed staff carrying out invasive procedures without proper equipment and appropriate clothing. Staff used a non-disposable tourniquet, their clothes and jewellery caused a potential infection risk and staff did not always wear protective gloves. When asked to describe their routine procedure with a patient, the phlebotomist did not include hand washing, either before or after patient contact. We notified managers of these issues and the trust informed us after the inspection that the issues had been resolved.

Environment and equipment

- Clinic and diagnostic imaging rooms were generally clean, organised and well-lit, and provided efficient treatment facilities. Audiology facilities were registered to an appropriate standard for hearing tests. All the electrical equipment we examined was tested appropriately. However the phlebotomy room was hot and cluttered, and was too small for the four patients seen at the same time.
- There was emergency resuscitation equipment in all departments. The resuscitation trolleys were checked daily. In one area the resuscitation trolley was kept in a locked clinic room that could be accessed by key pad entry. This could potentially delay access to the trolley in an emergency. Staff checked the contents of the trolleys daily and recorded these checks. We checked the contents of three resuscitation trolleys selected at random. In two of these there was no 'sepsis box' although this was in the contents list. Sepsis is a potentially life threatening infection which should be treated rapidly using a six-step protocol. If staff were unable to locate the proper equipment this could delay essential treatment.
- Some outpatient departments were overcrowded and patients were seated in other waiting areas, potentially leading to confusion and anxiety about waiting times.
- There were two magnetic resonance imaging (MRI) scanners providing services five or six days a week. Radiation lights were observed to be working in X-ray (fracture clinic) and in the computerised tomography (CT) department. In the mobile MRI scanner, support and radiography staff had an excellent understanding of MRI safety.
- Protective equipment used as protection against radiation was available for, and used by, radiology staff. This included lead (or equivalent) coats, tabards, aprons, gloves and lead rubber sheets. In line with legal requirements, equipment was checked annually and any found to be damaged and unacceptable for its intended use was removed from service and replaced. These checks were recorded on an electronic records system.

Medicines

- In outpatient areas medicines were stored and administered safely. Emergency drugs were stored in each CT room; some were stored in unlocked cupboards on the informal approval of pharmacy. There had been no formal risk assessment to make sure all potential risks were identified and adequately reduced.
- Sometimes when diagnostic scans are carried out the patient is injected with a chemical contrast agent to improve the clarity and diagnostic accuracy of the scan.Society of Radiographers guidance states that contrast agent injections should only be undertaken through appropriately authorised and documented local rules. In order to supply and administer these agents safely, there should be prescriptions (often called patient group or patient specific directions) that direct staff in delivering an appropriate dose.
- Radiology and radiography staff were not sufficiently aware of the need for prescriptions. Contrary to recognised guidance, a consultant radiologist said the responsibility to determine the correct dose was delegated to the radiographers. Radiographers carrying out these procedures we spoke with were unaware of practice guidance or protocols for these injections, although a more senior radiographer provided us with a policy and procedure. However this did not constitute a prescription as required.
- After we raised these concerns during the inspection, managers established a prescription process to include appropriate authorisation, dose and relevant protocols

Records

Outpatients and diagnostic imaging

- We looked at a sample of medical records and found they were legible and completed correctly. Individual MRI protocols were scanned with the patient referral and stored in the electronic records system so that all staff had access to them.
- Patients' notes were kept securely in each clinic. There was an effective and well organised medical records tracking and location system. It was rare that patients attended an appointment without their records being available. Medical records collection staff reported missing notes as incidents; there were one or two each month, out of approximately 25,000 appointments.
- Other issues with medical records were occasionally reported such as patient information filed in the wrong file or records being disorganised, but these were rare.

Safeguarding

- Safeguarding nurses were available to support outpatient staff at any time and there were clear procedures to follow on the intranet. Clinical and support staff were well informed about who to contact if they had concerns and gave us examples of appropriate referrals. Clinic areas had detailed noticeboards with information on safeguarding, consent, dementia and learning disability. Interventional radiology had recently introduced the World Health Organisation (WHO) Five Steps to Safer Surgery checklist, designed to prevent common and avoidable risks to patient safety during procedures. In radiology there was good compliance with the requirements of IR(ME)R to help keep patients and staff safe.
- Clinical, technical and administrative staff attended safeguarding training as part of their mandatory training. Trust figures showed that around 78% of outpatient and diagnostic imaging staff had attended adult safeguarding training and over 80% had attended level 1 children's safeguarding training. Neither of these met the trust target of 90%.
- Children attended some of the adult outpatient clinics on a daily basis. Staff working with children and young people should have appropriate training in safeguarding children. Level 3 training is for clinical staff that have key roles in assessing and treating children and young people. In the ENT department, only two of the eight nursing staff and none of the 15 audiologists had level 3 children's safeguarding training. As children attended daily, it was not possible to ensure adequately trained staff were on duty when a child attended. In the diabetes clinic none of the clinic staff had level 3 safeguarding training. Children over the age of eight attended the phlebotomy department, but none of the staff had received level 3 safeguarding training.

Mandatory training

- Trust staff attended annual mandatory training which included equality and diversity, fire, health and safety, information governance, infection control, manual handling, NHS conflict, resuscitation, and safeguarding. For clinical staff this took the form of a clinical update day.
- Trust data showed that very few staff groups met the trust target of 90% being up to date with mandatory training.
- Locally, managers did their best to organise staff to be able to attend, but with pressure on staffing levels this could be difficult to achieve.

Assessing and responding to patient risk

- Staff had clear protocols and referral systems to support them in assessing and managing patients who became unwell. When someone's health deteriorated staff took observations and used an 'early warning system' to determine appropriate actions. If necessary, medical staff liaised with the acute assessment unit and arranged for admission to an inpatient ward through the assessment unit. If the assessment unit was full, patients were transferred to the emergency department as a 'medically expected' patient. Following an audit, there were now panic buttons in outpatient clinic rooms.
- Each diagnostic area had a radiation protection supervisor. There was good liaison with the radiation protection team and staff were knowledgeable about safety procedures. In interventional radiology staff were familiar with emergency procedures.
- The IR(ME)R regulations require an employer to set diagnostic reference levels and provide staff with procedures on how they are to be used. This ensures patients are exposed to as little radiation as is clinically necessary. Clear national and local diagnostic reference levels were available in both CT scanning rooms. There were examples of dose audits carried out during September to December 2015, and these were used to guide practice. We saw good use of a technique that helps reduce the overall radiation dose to the patient and improve the image quality.

Outpatients and diagnostic imaging

- There were no diagnostic reference levels available in X-ray, and radiographers were unable to tell us where they were kept. A notice and risk assessments stated that dose levels were being audited so as to be able to produce local reference levels, but these were dated four years ago. An IR(ME)R clinical guideline in each room was overdue for review in November 2014. However, an updated version of the guidance was available on the trusts intranet.
- It transpired that paper notices had been removed before our inspection and replaced with laminated versions. The reference levels were available electronically, but radiographers we spoke with were unaware of this.
- We reviewed three clinical and health and safety policies in the X-ray department. All three were overdue for review so there was a risk they provided staff with out of date and unsafe guidance.
- In the mobile MRI scanner, both support and radiography staff were familiar with emergency procedures. There were clear signs posted near the 'phone to support staff in an emergency. However there had been no specific training on managing a cardiac arrest or similar emergency in the scanner. There had been no drills to practice evacuation from the scanner, which had limited space and was difficult to access.

Staffing

- Many outpatient clinics were consultant led, with nurses accompanying patients. Locum consultants were appointed to maintain clinic activity and medical recruitment was in progress across the teams, including joint appointments with a neighbouring provider. Consultants from a neighbouring trust held regular specialist clinics at the hospital in some specialities. Some specialist services were outsourced to another provider.
- Some clinics were led by nurses, pharmacists or therapists, and there were specialist nurse clinics in some areas such as the paediatric plaster room.
- Nursing and care support staff were deployed across clinics with skill mix determined according to patient need. Senior staff told us they did not use temporary agency staff. Bank usage between April and September 2015 averaged 8.9%. Usage had increased from 4% in April to 12% in September.
- From January to December 2015 the staff turnover in outpatients was 5.3% for registered nurses and 6.7% for unregistered nurses. However, in both circumstances this only corresponded to one staff member.
- Many departments were at risk due to poor staffing levels in all staff groups, medical, nursing, allied health, technical and administrative. Of the 42 items on the outpatient and radiology risk register, 14 (i.e. a third) were risks caused by inadequate staffing levels. A review of outpatient staffing was in progress, with an intention to complete this by January 2016.
- Although the trust provided us with data to show in June 2015 actual allied health professional staffing levels were 1 WTE above the planned establishment, the manager told us there was a high turnover of allied health professionals. There had been a 12% radiographer turn over in the previous 12 months. Managers were considering different working patterns and had held an open day recently, advertised on social media, but there were no other innovative recruitment approaches.
- Outpatient managers worked closely with service managers to set up additional clinics and keep waiting lists down.

Major incident awareness and training

- Departments had clear signs indicating emergency exit points and information about first aiders. Staff we spoke with had not taken part in any emergency evacuation or fire drills.
- The trust had a comprehensive major incident plan dated April 2015. This included actions to take in outpatients departments in response to a range of major incidents, and a response to radiological and nuclear incidents.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff used national and professional guidance when carrying out assessment, diagnosis and treatment. Some policies were overdue for review. Staff took part in a small number of local and national audits. Staff had good

opportunities for professional development but the outpatients and diagnostic services did not provide all staff with an annual performance appraisal. In some areas this fell well below the trust target of 90%

Very few services were provided seven days a week. There was effective multidisciplinary team working at local level, and staff could access the information they needed to deliver patient care. Staff usually obtained valid consent from patients. However, some staff demonstrated a poor understating of the Mental Capacity Act 2005 (MCA) despite training levels being 92%.

Evidence-based care and treatment

- Clinics were usually well organised and delivered effective assessment and treatment. Staff delivered evidence based care and followed National Institute for Health and Clinical Excellence (NICE) guidelines where relevant. Staff attended regular clinical team meetings where they learnt about new and updated guidance. For example, NICE guidance for gastroenterology.
- Some initiatives were taken in response to audits such as a new nasal reconstructive surgery (rhinoplasty) clinic following an audit on the care of patients attending with a broken nose.
- Local rules were clearly displayed in interventional radiology.
- There was a good system of recording MRI protocols, which had been developed following a serious incident earlier in the year.
- Dose levels were recorded in a dose record book in each diagnostic imaging room for patients and staff, in line with IRR 99 regulations. These were evaluated and reported on annually in the radiation protection adviser's report.

Patient outcomes

- There were some local and national audits taking place, including a local audit of the management of hand fractures and the National Audit for Cardiac Rehabilitation.
- The diabetic eye screening service achieved good levels of uptake between January and June 2015, with 82% of patients offered an appointment attending and 90% of those needing an urgent referral receiving a consultation within four weeks. Ninety nine per cent of results letters following the screening were sent within three weeks.
- Consultants and doctors attended regular specialty clinical governance and audit meetings, where they discussed cases and topics such as contrasting clinical outcomes between knee MRI and knee arthroscopy.
- There were approximately 2.6 follow-up appointments for every new appointment. This was similar to the England average.

Competent staff

- NHS organisations should provide staff with clear roles and responsibilities, personal development and line management support. An annual performance appraisal helps to deliver individual professional development and service improvement. The trust target was for 90% of staff to have received an annual appraisal. Outpatients and diagnostic departments did not meet this target. Trust figures showed the proportion of staff who had received an appraisal in the last 12 months was as low as 37% in the speciality group 'urology, vascular, and trauma and orthopaedics' and the greatest was 79% of staff in the group that included radiology and haematology staff. Staff we spoke with said the appraisals they had were useful and constructive.
- Staff we spoke with had received suitable induction on starting work. Agency radiographers were well supported in the department; their competencies were checked and they all signed the local rules. There was a clear process and induction checklist. There was a good process to check professional registration.
- Most staff we spoke with were very knowledgeable about their area of work and felt well supported by line managers to develop further skills, improve the service and attend training courses. Staff gave us examples of recent courses they had attended. There were good opportunities for professional development and most senior therapists were working towards Masters level qualifications. We observed staff taking on the role of practice educator and delivering good student support and supervision.
- A few staff groups felt de-valued and staff members told us they had not attended recent training or professional development activities.
- Most of the departments we visited held regular (weekly, fortnightly or monthly) staff meetings. There were monthly meetings for safeguarding and dementia leads, often with a training element built in.

Outpatients and diagnostic imaging

Multidisciplinary working

- In most departments there was effective multi-disciplinary team working, with regular multi-disciplinary team meetings. There was some involvement with other departments and external agencies, such as anaesthetic support in radiology and the external smoking cessation group in cardiology.
- Some services, including haematology, clearly worked with a range of services providing patient care. There were regular outpatient management meetings with the clinical commissioning group and external health and social care providers.

Seven-day services

- Most outpatient services were provided Monday to Friday, during working hours, with a small number of additional evening and weekend clinics.
- In radiology, the MRI service was available Monday to Saturday for 12 hours a day. On Sundays there were ad hoc and private patient clinics. CT scans were available seven days a week with on call provision out of hours. Other diagnostic imaging services were provided Monday to Friday with occasional weekend clinics, and emergency cover through the emergency department.
- Interventional radiology was provided three days a week.

Access to information

- The efficient medical records tracking and location system made sure that staff were able to access patient information when they needed it.
- Staff also used a pneumatic (vacuum) tube system to transport urgent referrals and samples swiftly between departments.
- Diagnostic imaging staff could access test results from other providers immediately through an electronic system.
- Diagnostic imaging results were scanned onto the electronic patient system so that they could be accessed by staff throughout the trust as required.
- Following an outpatient appointment, the clinic sent a letter to the patient's GP. Trust information showed that about a quarter of patients' GPs did not receive a letter, and just more than half of the letters were sent within the target timescale. The trust reported that this was in part due to administrative error in logging the letters which had in fact been sent. A divisional director told us improvements in the proportion of letters sent promptly would be made by the end of January 2016.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at consent forms in several departments and found they were used appropriately to record patients' valid consent. In interventional radiology all patients gave verbal and written consent. We observed a patient giving consent to a procedure; they were very concerned about the procedure and staff explained everything clearly and ensured the patient had all the information and time they needed to give consent.
- Some staff were aware of the legal requirements of the Mental Capacity Act 2005 (MCA), and took steps to take decisions in the best interests of patients who were unable to make decisions about care themselves. They understood correct procedures in the event of medical emergencies.
- Other staff demonstrated poor understanding of the MCA. For example, staff would ask relatives to provide consent without first checking if the relative was legally authorised to do so.
- Figures provided by the trust showed that 92% of outpatient and diagnostic staff had attended MCA training within the last three years.

Are outpatient and diagnostic imaging services caring?

Good

Staff treated patients and their relatives with dignity and respect; virtually all the patients we spoke with reported positive experiences and caring staff.

Staff in a range of roles spent time with patients to make sure they understood procedures and to put them at ease. Patients were given sufficient information to make decisions about their treatment and felt they were well informed.

Outpatients and diagnostic imaging

Staff responded with kindness and compassion when patients needed emotional support. We observed some careless interactions when patients' confidentiality was not respected, but these were in the minority and balanced by overwhelmingly caring attitudes and good communication.

Compassionate care

- Patients were usually treated with dignity and respect. Many patients told us staff were friendly, polite and kind. Staff established rapport with patients and relatives to help put them at ease. One patient attending for blood tests told us they had a fear of needles but the staff always put them at ease.
- In outpatient departments nursing and care staff usually accompanied patients from the waiting area to the treatment room. They provided assistance as needed and spoke with patients clearly and discreetly, making good eye contact. Patients told us staff treated them as individuals, and got to know them if they were regular attenders.
- In phlebotomy, there was no privacy. Staff carried out procedures with four patients sitting close together in a small room, without audible or visual privacy. Patients were asked their personal details in front of others.
- Orthopaedic clinics frequently took place in 'over flow' areas including the breast clinic. This meant 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. A breast clinic patient reported they were left in a state of undress for 20 minutes waiting for the doctor.
- In some clinic rooms it was possible to overhear the consultation taking place in the neighbouring treatment room. In one area, we observed staff repeatedly entering a room where a patient consultation was in progress, leaving the door open for several minutes at a time. In the waiting area we (and presumably the other patients) could hear the conversation between doctor and patient while the door was left open.
- Patients may find some consultations, examinations or treatments distressing and may like to have a chaperone present. When a patient needs to undress they may feel vulnerable, and a chaperone can act as a safeguard for both patient and clinician. It is good practice to make patients aware they might request a chaperone. Receptionists in several outpatient clinics were unable to provide us with any patient information on chaperones and we did not see any information on display in outpatient departments. Senior staff told us patients were normally accompanied by a nurse in a consultation but this did not happen in all clinics.
- Outpatient staff told us they had recently started a patient opinion survey, as they were no longer receiving feedback from the Friends and Family Test survey. Staff had designed a short survey and this was handed to patients on an ad hoc basis and left in waiting rooms for people to pick up. There were 307 respondents to date. These had been collected every fortnight and collated by one of the senior sisters since November 2015. The findings from the patient opinion survey showed that 66% of patients felt their experience of the service was excellent, 23% of patients felt it was very good and 10% of patients felt it was good. Only 1% of patient felt their experience was poor.

Understanding and involvement of patients and those close to them

- Staff usually kept patients informed if there was going to be a longer than expected wait, and patients were able to leave the department with their numbered ticket and come back later without losing their place in the queue. A nurse offered a patient the opportunity to see the registrar rather than wait for a consultant whose clinic was running late. The nurse respected their decision to wait and see the consultant.
- We observed staff building rapport with patients and putting them at ease before their procedure. They used humour appropriately. Staff gave patients sufficient information including any possible side effects and likely outcomes. Throughout a procedure we saw staff talking with the patient to explain what was happening and to keep them informed.
- Patients told us staff kept them informed about their care and treatment; they explained everything well and gave them time to ask questions. Patients we spoke with were well informed about what was happening and where they had to go next.

Emotional support

- Staff were reassuring and encouraging. We saw staff treating patients with kindness during procedures. A doctor took time to reassure a patient and demonstrated compassion. All team members were equally empathic, patient and caring.

Outpatients and diagnostic imaging

- We spoke with a patient before their appointment and they were very nervous. Afterwards they said the nurse had been helpful, reassuring and understanding and they now felt much better.
- There was a small carers lounge where carers could meet carer support workers and representatives from local patient support groups. Staff offered advice, support and information. Staff told us they promoted the lounge in outpatients departments.

Are outpatient and diagnostic imaging services responsive?

Good

Access to services was well managed. Waiting times for appointments met the national standards and patients were able to attend appointments swiftly. The trust performed better than the England average from September 2014 to August 2015. Staff ran additional evening and weekend clinics to reduce any increased waiting lists.

All patients who were newly diagnosed with a cancer waited no longer than the national standard of 31 days from the date of decision to treat to receiving their first treatment, between October 2013 and June 2015. This was consistently better than the England average.

There was an effective booking system. Patients received clear appointment letters, explaining the purpose of the appointment, how to find the clinic, what they needed to bring and who to contact with any questions or to re-arrange.

Each clinic had link nurses or practitioners for dementia who supported staff when caring for people with additional needs. However, services did not always meet people's needs and the needs of the local population were not fully identified or taken into account.

Despite serving a multi-cultural population, outpatient and diagnostic services did not provide patient information in formats other than written English.

Service planning and delivery to meet the needs of local people

- Bedford Hospital provided a range of outpatient and diagnostic imaging services to meet people's needs. Routine and more specialist services were provided for people living locally in north and mid Bedfordshire, as well as the vascular hub for the county of Bedfordshire.
- Staff sometimes set up additional evening and weekend clinics to manage waiting lists caused by staff shortages or equipment failure. Diagnostic imaging services were able to provide out of hours and emergency cover. Extra MRI clinics were put on to accommodate children.
- Staff did not monitor the demographics of people attending or failing to attend appointments and therefore could not use this type of information to inform how services were planned and delivered.
- Patients received clear appointment letters, explaining the purpose of the appointment, what they needed to bring and who to contact with any questions or to re-arrange. Most patients we spoke with told us they received useful directions to the department and had not found it difficult to locate, although signage could be clearer.
- Several patients complained about the difficulties finding a car parking space.
- Ambulance patients were offered a snack and a drink if they were waiting for transport over lunch time.
- Many waiting areas were small and could get over-crowded when busy. There were different types of seating for patients but often no spaces for patients using wheelchairs, and they had to wait in corridors. Overcrowding of some areas was on the trust's risk register and there were plans to move clinics to other locations.
- Most waiting areas had information leaflets, and some had background music. There were no televisions and minimal child-friendly facilities. The environment did not consistently meet the needs of people with dementia or with visual impairment. Flooring was often shiny or had variegated patterns, and its colour did not contrast with the walls. Signs were not always clearly visible and we did not see any large faced clocks in waiting areas.
- Although there were several remote waiting areas in diagnostic imaging, staff visited these areas every few minutes to ensure patients' safety. There were both mixed and single-gender waiting areas.

Access and flow

Outpatients and diagnostic imaging

- There was a draft patient access policy dated November 2015 that was later ratified in January 2016. The purpose of this was to set out best practice for staff to manage the flow of patients through the hospital from first referral to discharge.
- Patients were referred to outpatient services by their GPs, hospital consultants and other practitioners such as opticians. Some departments had walk-in clinics which patients could attend without an appointment. Most teams told us they could provide urgent appointments within one or two weeks.
- After referrals were prioritised by clinical staff, booking staff 'phoned patients to offer them a choice of two appointments. If staff could not contact patients by 'phone that working day they sent the patient a letter. Patients could then phone to re-arrange if necessary or could do this online. Each speciality had its own appointment letter template. The butterfly scheme promoted by the hospital advocates particular wording in an appointment letter for patients with memory problems. There were no letter templates with additional or different information for patients with dementia or a learning disability.
- Most patients were seen within 18 weeks of their referral reaching the hospital. The national standard for NHS trusts that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral was withdrawn in June 2015. The trust met the standard for non-admitted patients for all but one out of 23 months between July 2013 and May 2015. The trust also performed better than the England average from September 2014 to August 2015.
- 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.
- The national cancer waiting time standard is that at least 93% of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen in hospital. The trust met this target for most of the period April 2013 to June 2015.
- All patients who were newly diagnosed with a cancer waited no longer than the national standard of 31 days from the date of decision to treat to receiving their first treatment, between October 2013 and June 2015. This was consistently better than the England average. All patients who are urgently referred by their GP with a suspicion of cancer who are subsequently diagnosed with cancer should wait no longer than 62 days to start treatment. The trust performed better than the England average between July 2013 and June 2015, with around 90% of referred patients waiting less than 62 days.
- Since January 2014, the trust had performed well in providing 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. The radiology department reported on diagnostic images swiftly, on the same day for inpatients and over half of all patients. Ninety eight per cent of results were provided within ten days. Cardiology also reported on test results the same day.
- The number of follow up appointments compared with first appointments influences how many newly referred patients can be seen and meet the waiting times standards. A lower ratio improves patient flow. The follow-up to new ratio was about the same as the England average and similar to the majority of other trusts.
- Between July 2014 and June 2015, the percentage of appointments which booked patients failed to attend was around 7 to 8%. This was similar to the England average of approximately 7%. If patients failed to attend urgent referrals for cancer, staff rang them to find out the reason and re-arrange if appropriate. Other patients were referred back to their doctor.
- The trust did not audit the number of patients who waited more than 30 minutes to see a clinician, or the number of clinics which started late. In some areas staff carried out ad hoc waiting times audits. In the diabetes clinic the audit found that a third of patients waited longer than ten minutes after their appointment time to see the clinician.
- Most reception staff kept patients informed if clinics were running late, but they did not have guidance or protocols on managing patients who were waiting longer than their appointment time. In fracture clinic patients waiting for X-ray did not know how long they would have to wait unless they asked. Emergency department patients took priority for use of the X-ray room.

Meeting people's individual needs

Outpatients and diagnostic imaging

- Bedford Hospital serves a multi-cultural population. In urban areas of Bedford Borough, more than a third of the population is from minority ethnic groups compared to just over a tenth in rural areas. Bedford Borough's black and minority ethnic population increased from 19.2% in 2001 to 28.5% in the latest 2011 census. Much of the rise was due to migration from new European Union countries, including Poland and Lithuania, as well as from countries such as Afghanistan and Zimbabwe.
- Most outpatient and diagnostic imaging waiting areas had patient information on display, either in racks or on notice boards. Outpatient and diagnostic departments did not have information in formats other than written English, such as easy read, other languages or braille. When we asked reception staff they were unable to tell us how these could be provided if required.
- Many elderly patients and those with hearing loss find it difficult to hear conversation at a reception desk and in a busy waiting area. None of the departments we visited used a hearing loop to improve the quality of communication for people wearing hearing aids. When we asked reception staff they had no knowledge of this.
- Trust information showed that in the six months May to October 2015, 79 telephone and 55 personal interpreters were booked. These were booked for a range of clinics, but there was no information about the language required. It was therefore impossible for managers to evaluate the usefulness of the interpreters. We met two patients who did not speak English well and always attended appointments with their adult son to act as interpreter. They were unaware of the interpreting service.
- Staff used white boards or verbal announcements to inform patients of clinic delays and waiting times. Writing on whiteboards was often small and difficult to read, and the information was updated sporadically.
- Each clinic had link nurses or practitioners for dementia who supported staff when caring for people with additional needs. Those we spoke with had attended an accredited dementia awareness course. There was a lead learning disability nurse who was well known by staff who contacted them for advice and support. They would attend appointments with patients when appropriate.

Learning from complaints and concerns

- It is good practice to ensure patients can easily make a complaint if they need to and have access to information and guidance in appropriate languages and formats. None of the departments we visited provided patient information and guidance on how to complain. Staff did not have a good understanding of complaints management. Virtually all the staff we asked told us they would direct complainants to the Patient Advice and Liaison Service (PALS). This was not in line with recognised national guidance or the trust's Complaints/ Concerns Policy. There was no protocol for guiding staff in how to manage complaints and senior staff told us they had not received training in responding to complaints, other than conflict resolution.
- Outpatient staff told us they had recently started a patient opinion survey, as they were no longer receiving feedback from the Friends and Family Test survey. Staff had designed a short survey and this was handed to patients on an ad hoc basis and left in waiting rooms for people to pick up. There were 307 respondents to date. These had been collected every fortnight and collated by one of the senior sisters since November 2015. They shared the feedback verbally with staff at morning staff meetings. Staff told us that findings from the survey led to staff making regular announcements every half hour when clinics were running late and gave them a call waiting slip.
- In most departments staff told us they carried out their own patient experience surveys. In some outpatient areas, such as ENT, there was no suggestion box or information for patients on how to provide feedback. Of the feedback systems we saw, response numbers were small. Staff told us they discussed patient comments in team meetings and had made some changes as a result.
- Senior staff we spoke with told us they extracted the information on complaints from the trust's electronic reporting system. They told us they did not get analytical reports on themes and action plans in response to patient compliments, concerns and complaints, which would support service improvement. We saw a monthly complaints and accolades report that went to the radiology clinical governance group, but this was simply a list of the comments received. We looked at minutes from outpatient quality and safety meetings in April, July and November 2015. At one meeting two patient complaints were outlined with subsequent actions. There were no discussions of outcomes from patient feedback or opinion surveys.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The leadership, governance and culture did not always support the delivery of high quality assessment and treatment. There was no clear vision or strategy for the services.

Governance and risk management systems did not consistently operate effectively and risks were not always managed in a timely way.

Overall staff were positive about working in their teams and felt well supported by managers. Staff satisfaction was mixed although largely positive, and although staff were able to make suggestions to improve services this was done in an ad hoc way.

There was some but limited involvement of patients, the public and other care agencies in developing services, and limited innovation.

Vision and strategy for this service

- There were plans to develop an outpatient improvement strategy, and the first meeting of the programme board was expected to be at the end of January 2016.
- Staff did not articulate a clear vision for outpatients and diagnostic services.

Governance, risk management and quality measurement

- The trust had two clinical divisions, planned care and integrated medicine. Each division had five speciality groups. Outpatient and diagnostic services were managed within both divisions for example through the radiology, cancer and endocrinology groups in the division of integrated medicine and the urology, vascular and trauma and orthopaedics, and therapies, pharmacy and outpatient department groups in the division of planned care.
- Senior clinical staff we spoke with were not always clear on governance structures. It was unclear how risks were effectively managed when they crossed divisions. For example the over-crowding in phlebotomy was escalated through the planned care governance structure but 'owned' by the integrated medicine division.
- We asked to see minutes from recent planned care divisional governance meetings. The trust provided us with surgery and anaesthetics quality group minutes for September, October and November 2015. Risks and the risk register were discussed at each meeting. Feedback or reports from the trust quality board and risk and compliance board, the quality scorecard, the nursing quality dashboard and the ward/sisters/department meeting were standing items on the agenda. There were no reports for any of these at any of the three meetings other than a report on the quality scorecard at one meeting. In September, five complaints relating to outpatient departments were discussed. These were not followed up at subsequent meetings as suitable information was unavailable.
- There were monthly performance and quality meetings for the allied health professional leads. These provided a way of communicating and learning across specialities. A few staff groups in more specialised areas told us they did not feed into any governance structures. They told us about risks they had highlighted to managers, which had not been escalated. We saw these risks were in fact on the risk register but the staff had not received feedback on mitigating actions taken.
- We looked at integrated medicine executive management committee reports to the trust quality board in July and August 2015. These reported cancer and other outpatient and diagnostic waiting times, but no other performance data. There were also workforce reports including absence and vacancy rates, and training and appraisal data, which both fell well below the trust target of 90%. High risks from the divisional risk register were included in the report to quality board as part of the escalation to the trust risk register, where steps to manage the risks were also monitored.
- The radiology risk register for September 2015 had 13 identified risks. Nine had review dates between March and May 2015 so we were not assured these risks were effectively monitored and reduced. There were ten radiology risks on the October 2015 corporate risk register. Three unresolved risks rated as moderate or 'amber' on the radiology risk register did not appear on the corporate risk register as expected. Not all risks were effectively managed such as prescriptions for contrast

agents, which some senior staff had raised as a concern, and the provision of diagnostic reference levels and protocols. When we raised these issues during the inspection, managers were swift to put proper processes in place, but had not previously recognised the urgency or legal requirements.

- There were 42 identified risks on the 'outpatients and diagnostic testing risk register' for October 2015. This was provided for the inspection and was an extract from the corporate risk register, so did not show how risks were managed at department level or escalated and managed at trust wide level.
- Main risks were to do with staffing capacity, clinic capacity, commissioned pathways of care and equipment. Overall steps to reduce risks were clearly documented.
- There was clear oversight of waiting times in outpatients and diagnostic services, but there was little other quality or performance information available for senior clinicians and managers. A quality dashboard was in the early stages of consideration.
- Department waiting areas did not display performance information for staff, patients and visitors, such as on cleanliness, patient satisfaction, waiting times or accessibility, which is common in other hospitals. It is informative for patients and gives staff a sense of pride in their department and ambition to improve.
- There is evidence that telephone or SMS text message reminders substantially reduce missed appointments and many NHS trusts offer patients SMS text reminders of their appointments. Bedford Hospital provided this in some clinical areas and was planning to extend to all areas in the future.
- Outpatient managers told us they attended a data quality meeting that was held jointly with the lead clinical commissioning group.
- The interventional radiology service had become understaffed two years ago and there had been a cluster of adverse events during 2015. This led to a focus on quality improvement and an investigation identified several priorities. The department met daily until satisfied improvements were made.
- Bedford Hospital provided an elective and emergency vascular hub for Bedfordshire and Luton. The interventional radiology service which forms an integral part of this was only available three days a week. There was only one interventional radiology suite, one consultant radiologist and no out of hours cover. Royal College of Radiologists' guidelines state that as an elective and emergency service it should be available 24 hours a day seven days a week, and if not there should be formal arrangements with other hospitals for managing patients. There should be up to six specialist radiologists and a formal 'out of hours' rota. The trust did not have a formalised agreement for patients that require interventional radiological procedures out of hours. The trust told us they believed a local NHS trust had plans to develop an agreement for out of hours interventional radiological, which the trust anticipated will include patients at Bedford. The lack of staff capacity in relation to both radiologists and specialist nurses had been on the risk register since April 2014.
- Managers and senior clinicians were unable to effectively evaluate and address the causes and potential impact of cancellations. The trust reported that outpatient clinics were rarely cancelled, and if a patient's appointment was cancelled it was re-booked within one week. The trust did not provide a percentage of total outpatient clinics that were cancelled but figures showed during the eight months April to November 2015 more than 26,000 patient appointments were cancelled. A quarter of these at the patient's request. More than a half of all cancelled appointments were for reasons 'not specified'. If patients cancelled an appointment more than three times they were referred back to their referrer; if they met the criteria of being vulnerable, hospital staff informed the patient's GP and the child protection team if appropriate.

Leadership of service

- Outpatient services were led by a divisional director for planned care. Diagnostic services were led by an assistance divisional director for integrated medicine.
- Senior members of the executive team were not well known. A staff member remarked that the photographs of the executive team in the main entrance had only appeared a week before the inspection.
- Local department managers were generally well known and seen to be supportive by staff. In recent years the radiology department had many managerial changes and staff upheavals. This made some staff feel unvalued and they perceived a lack of investment in the department. A new manager had been appointed in the autumn who was working to build bridges between front line staff and senior managers.

- Each department had their own human resources (HR) adviser who provided managers with effective support in performance management. HR policies had recently improved which helped managers when dealing with difficult situations.
- Most qualified nurses were on the NHS leadership programme.
- We were told but did not see data to support that there were persistent problems with staffing levels in clinical and administrative groups. This led to low morale and a 'firefighting' approach. Administrative staff told us they rarely had time for staff meetings to discuss and try to resolve problems.

Culture within the service

- During our inspection staff were relaxed and friendly. They demonstrated commitment to providing a good service for patients. Many staff told us they enjoyed working at the hospital and many had worked there for several years. Staff in a variety of roles told us they felt well supported by managers and worked effectively in their teams.
- Other staff groups, including administrative, clinical and technical, told us there was low morale in their teams and they felt taken for granted or excluded from the general running of the hospital. Several staff members described ineffective line management arrangements, which led to lack of accountability and oversight.

Public and staff engagement

- Staff were involved in service development through discussions in team meetings. Throughout the inspection staff gave us examples of small changes that had been made following staff suggestions to help improve the patient experience. It was apparent that staff felt able to make suggestions and contribute to developing new ways of working, such as improved dignity for female patients in cardiology.
- The new radiology manager told us they met with all staff individually after commencing the role to identify issues and suggestions from staff. They planned to do this annually.
- There was a patient council which had taken part in clinical studies of the outpatient clinics. Staff told us they had made changes such as timings of clinics to prevent bottlenecks at X-ray as a result of the patient council involvement. However, the trust informed us that there were no reports available that had the involvement of the patient council. The service lead reported that members of the patient council would be invited to the outpatients steering group in future and this would lead to further patient council involvement in future clinical studies.
- Staff told us there were user groups, such as for diabetes, involved in both inpatient and outpatient services, but we did not see any outcomes from these groups.

Innovation, improvement and sustainability

- There was a draft outpatient strategy which proposed to look at ways of integrating services into the community and strengthen working with other agencies.
- The trust reported the display of reminiscence photographs in the quiet area of the main outpatients department was much appreciated by patients.
- The trust worked with a neighbouring trust to make joint clinical appointments so as to facilitate services in both trusts.
- The carers lounge was promoted in outpatients departments and provided a useful resource and link with community support groups.

Chemotherapy

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	**Not sufficient evidence to rate**

Information about the service

Summary of findings

Chemotherapy

Are chemotherapy services safe?

Are chemotherapy services effective?

Are chemotherapy services caring?

Are chemotherapy services responsive?

Are chemotherapy services well-led?

Radiotherapy

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	**Not sufficient evidence to rate**

Information about the service

Summary of findings

Radiotherapy

Are radiotherapy services safe?

Are radiotherapy services responsive?

Are radiotherapy services effective?

Are radiotherapy services well-led?

Are radiotherapy services caring?

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 hospital 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 give consent, staff must act in accordance with the requirement 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 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.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should ensure all vacancies are recruited to.
- The trust should ensure all staff have received their required mandatory training to ensure they are competent to fulfil their role. Including safeguarding training.
- The trust should ensure staff receive and appraisal to meet the appraisal target of 90% compliance.
- The trust should ensure that all trust policies are up to date and that they are consistently followed by staff.
- The trust should ensure that patient information can be accessed in different languages.
- The trust should ensure all equipment has safety and service checks in accordance with policy and manufacturer' instructions and that the identified frequency is adhered to.
- The trust should ensure all equipment is in date.
- The trust should ensure facilities for paediatric patients meet national guidelines.
- The trust should ensure facilities for patients with mental health needs meet national guidelines.
- The trust should ensure ligature points are identified and associated risks are mitigated to protect patients from harm.
- The trust should ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum.
- The trust should ensure delays in ambulance handover times are reduced to meet the national targets.
- The trust should ensure that infection control practices are followed by staff.
- The trust should consider reviewing the admission process for elective surgery are in line with national guidance and to ensure patient privacy and dignity is maintained, with assessments completed in rooms with adequate equipment to meet patient needs.
- Ensure that records of all patients diagnosed with sepsis contain the 'Sepsis Six' sticker to alert staff to the patients diagnosis as per national guidance
- The trust should ensure that action plans are in place to improve patient outcomes against national audits.
- The trust should ensure staff that are involved in blood transfusion are up to date with competencies and training.
- The trust should ensure all drug cupboards and medication fridges are in good working order and locked at all times to maintain safe use of drugs.
- The trust should ensure patient records are stored safely.
- The trust should ensure patients belongings are kept safe at all times.
- The trust should ensure that they implement follow up clinics for critical care patients, as recommended in NICE guidance
- The trust should ensure that staff document and monitor the time and decision to admit to the critical care complex.
- The trust should reduce delays experienced by patients in transferring to a ward bed when they no longer required critical care.

Outstanding practice and areas for improvement

- The trust should ensure that they assess all surgical patients with mortality risk of between 5 and 10% for admission to the critical care complex.
- The trust should ensure that all medicines are within the recommended date.
- The trust should ensure that medicines are stored appropriately.
- The trust should ensure that controlled drugs records are kept up to date and are accurate.
- This trust should review the entrance to the gynaecology ward to ensure the needs of all patients are met.
- The trust should develop a policy on restraint and / or supportive holding and staff should receive training to ensure they understand how to apply the policy.
- The trust should ensure that safeguarding referrals are made in line with trust policy.
- The trust should patient observations are taken and recorded in line with the agreed time frames according to their risk assessment.
- The trust should ensure pain assessments for children are consistently completed.
- The trust should ensure that there a concealment trolley appropriate for bariatric patients.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 (1) (2) (3) HSCA 2008 (Regulated Activities) Regulations 2014 **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.
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

This section is primarily information for the provider

Requirement notices

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.

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.